A Comparison of the Effect of Pre-Treatment Questionnaires on Therapeutic Alliance and Attendance Rates

Ailie Castle

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Declaration

"I certify this is a true and accurate account of the work carried out. This thesis has been composed by myself and the work contained herein is my own."

Signed _

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Abstract

Efficacy studies are one of the most common designs in psychotherapy, aiming to demonstrate the effectiveness of a particular type of treatment for a particular disorder. However as Seligman (1995) argues, this design omits a number of important factors in therapy. These factors have been identified as 'common factors'. Hubble, Duncan and Miller (1999) point to these factors as accounting for what works in therapy. The therapeutic alliance has been identified as one of the most important factors in therapy and has been positively associated with outcome. Solution-Focussed Therapy (SFT) utilises the therapeutic alliance and advocates the use of a number of techniques, such as recognising pre-treatment improvement, in order to promote hope, expectancy and motivation. A number of studies have suggested that these techniques may improve attendance at therapy and therapeutic alliance.

This study aimed to determine whether administering a more solution-oriented questionnaire prior to treatment, compared to a more pathology focussed questionnaire, would have a positive impact on therapeutic alliance and attendance at therapy.

All patients offered a new appointment from 1st July 2000 at an adult clinical psychology department in Tayside were asked to participate in the study. The study comprised 3 experimental groups; a group receiving the pathology focussed questionnaire (The Symptom Checklist – 90 revised); a group receiving the solution-focussed questionnaire (Solution-Focussed Intake Form); and a control group, receiving no questionnaire. The secretary randomly assigned patients to one group when the initial appointment was offered. At the third session, all subjects were asked to complete the Session Rating Form, which measures therapeutic alliance.

Differences between the groups on therapeutic alliance scores and attendance were explored. The results are discussed with reference to the previous research findings.

CHAPTER 1 : INTRODUCTION

1.1 General Introduction

Academic training in clinical psychology has included teaching on many therapeutic approaches; cognitive-behavioural, solution-focussed; psychoanalytic psychotherapy, cognitive analytic therapy, inter-personal therapy and dialectic behavioural therapy. Clinical practice involves implementing these varied techniques in relation to different clients and different problems. However when asking clients what has helped them to improve within therapy it is often not these techniques to which they immediately refer.

Often it is the 'non-specific' aspects of therapy that have significantly contributed to the therapeutic change. This has stimulated interest in other aspects of the therapeutic process and in particular, the therapeutic alliance. Depending upon the textbooks read and the orientation of a supervisor this can either be emphasised or neglected. The purpose of this study is not to undermine the importance of specific psychological therapies or different therapeutic orientations. These remain important. However there has been an assumption that efficacy studies using randomised controlled designs are the 'gold standard' in psychotherapy research. As will be shown later, this assumption has been criticised by a number of respected clinicians and researchers.

The first section of the introduction provides an overview of 50 years of psychotherapy outcome research. It will be argued that specificity research, the most common research design, has a number of flaws and that effectiveness studies are perhaps more reflective of actual clinical practice. This will be followed by a

discussion of what factors account for what works in therapy and how each contributes to the therapeutic process. The second section will discuss the importance of the therapeutic alliance; the many definitions and measures which exist; the validity and reliability of the therapeutic alliance as a clinical construct; its association with positive therapeutic outcome; and how it will be measured in this study. The third section will look briefly at the influence of solution-focussed therapy and how its techniques and style have informed clinical practice. In particular the use of pre-treatment change and its effect on attendance will be discussed. This will then lead in to the main aims and hypotheses of this study. The main aim being whether administering a questionnaire, which focuses on solutions to problems and strengths, rather than a questionnaire which measures symptomatology, prior to treatment can have an impact on attendance and on therapeutic alliance.

There will then follow a description of both the design and method used to test the hypotheses. The results from the study will be presented and a discussion of the main findings will follow. The possible explanations for the findings and the implications for future research will be addressed.

1.2 WHAT WORKS IN THERAPY?

1.2.1 Introduction

The purpose of this chapter is to explore what is effective in psychotherapy, and how the research informs on practice. The chapter begins with the assertion that specificity research is perhaps flawed and based upon a number of misconceptions. The evidence from over 50 years of outcome research does not point towards specific treatments for specific disorders and despite the importance of efficacy studies there is a strong argument for effectiveness studies. These studies not only reflect what is actually done clinically, but also point towards what actually works in therapy.

1.2.2 The Specificity Myth

The tradition within mental health, over the years, has been that there are specific treatments for specific disorders. As Bozarth and Schneider (2000) argue in a paper presented to the American Psychological Association on 'The Specificity Myth', mental health treatment in the United States, and Europe, has been built upon a "fallacious premise". They argue that this myth, which has been perpetuated from the medical model and behavioural treatment models, is unsubstantiated.

The myth is based upon the assumption that psychiatric diagnosis is valid, which incorporates a further 2 assumptions. Firstly, it assumes a relationship among certain phenomena from which the concept of a diagnostic label can be determined. Secondly, it assumes a binding of the clusters identified by researchers. Bozarth and

Schneider (2000) argue that both these assumptions are lacking in validity in relation to psychiatric diagnoses.

A useful example, which highlights the integral problems of psychiatric diagnoses, would be the diagnosis of 'schizophrenia'. Bozarth (1999) asserts that in the 1950s, schizophrenia was used as a 'catch all' diagnosis for those people who did not fit other diagnostic categories. Boyle (1999) stated,

> there is no evidence whatsoever that the original introduction of the concept of schizophrenia was accompanied by the observation of a meaningful relationship amongst the many behaviours and experiences from which the concept was inferred (p 80).

Further, statistical studies which have been performed, do not show any evidence for a cluster of symptoms in patients diagnosed with schizophrenia (Bentall, 1990; Slade and Cooper, 1979).

Bozarth and Schneider (2000) argue that other studies have shown a similar lack of evidence for other diagnostic concepts, for example in depression (Wiener, 1989), panic disorder (Hallam, 1989), and agoraphobia (Hallam, 1983). Boyle (1999) contends that psychiatric diagnoses were developed by medics to suit bodily processes rather than people's behaviour and experience. Further, a non-diagnostic approach would demand different assumptions and therefore different therapeutic responses. It would seem therefore, that there is a counter-argument, which is against the assumption that people's behaviours can be categorised and treated in a

formal and structured manner. This is based on previous studies cited above which would argue that diagnostic concepts are invalid and people classified with a particular disorder may have very different symptoms or behaviours to another person with the same classification.

However, Bozarth and Schneider (2000) argue these assumptions form the basis of the current mental health system and subsequent treatment. They argue these assumptions are ignored, and year after year, diagnostic manuals such as the American Diagnostic and Statistical Manual of Mental Disorders (4th edition [DSM-IV]; American Psychiatric Association, 1994) and the International Statistical Classification of Diseases and Related Health Problems (10th Revision [ICD-10]; the World Health Organisation, 1992) are re-published. The manuals claim to provide, "...clear descriptions of diagnostic categories..." and to enable investigators "...to diagnose, communicate about, study, and treat people with various mental disorders..." (American Psychiatric Association, p xxvii). However despite such apparent 'strengths' the manuals do not provide recommendations for treatment. Bozarth and Schneider (2000) suggest such manuals raise many unanswered questions about the usage of diagnosis. If it is to inform of the most appropriate treatment, why is this not provided? They conclude with the example that once, homosexuality was a diagnostic criteria, requiring treatment for deviant pathology. Today 'Gay and Lesbian Issues' is a division of the American Psychological Association, providing recognition for this group and promoting their acceptance within society. This reversal from 'deviancy' to 'acceptance and promotion' clearly indicates the vulnerability of medical diagnoses to the attitudes of society.

Within the field of psychotherapy outcome research, there has been a trend towards specificity research, that is studies which point towards a specific treatment for a specific disorder, despite the misgivings described above. This research has failed to build on the outcome findings of the past 40 years. Luborsky, Singer and Luborsky (1975) reviewed comparative psychotherapy studies. They concluded that there was equivalence in the effectiveness of all therapies. Using the 'Dodo Bird' metaphor from 'Alice in Wonderland' Luborsky et al (1975) compared psychotherapy studies to the race. There was a race but the animals ran in different directions. The race was stopped and the Dodo bird asked, "Who has won?" He finally concluded that, "Everybody has won, and all must have prizes." Luborsky et al (1975) used this metaphor to illustrate that all therapies, like the runners, should be considered equally effective. Similar to the runners, whilst the different studies may appear to approach therapy from a different angle, the outcome is generally the same.

1.2.3 Evaluation of Psychotherapy Outcome Research

The 'Dodo Bird' study suggested that common factors are likely to be the source of the equivalence amongst different therapies. Stubbs and Bozarth's (1994) article, 'The Dodo Bird revisited' asserted 5 categories characterised the evolution of psychotherapy outcome research. These categories are summarised by Bozarth and Schneider (2000) as follows:

Category 1: Psychotherapy is no more effective than no psychotherapy (1950s, and 1960s).

Eysenck's (1952; 1966) hypothesis that psychotherapy is no more effective than no psychotherapy caused considerable reaction and criticism (Bergin, 1971). Eysenck's original research in 1952, which comprised 19 studies and approximately 7000 neurotic patients, concluded that psychotherapy is no more effective than no therapeutic treatment. This conclusion was based on the premise that two-thirds of the patients involved with psychotherapy improved within 2 years, and a similar proportion of the same population improved without therapy (Stubbs and Bozarth, 1994). In 1966 Eysenck conducted a survey from his 1952 study, involving various types of therapy and controlled outcome studies. Mixing together these findings he concluded, "psychologists and psychiatrists will have to acknowledge the fact that current psychotherapeutic procedures have not lived up to the hopes that greeted their emergence fifty years ago" (Eysenck, 1966, p40).

Unsurprisingly there was considerable reaction to this claim. Some suggested Eysenck's method was flawed (e.g. Rosenzweig, 1954). Others such as Bergin (1971) re-evaluated the studies but given the ambiguity, lack of objectivity, and evidence of incorrect empirical computations the debate of the validity and applicability of the studies was impossible to resolve (Stubbs and Bozarth, 1994). Later meta-analyses of psychotherapy confirmed its effectiveness and Eysenck's hypothesis was later refuted.

Category 2: The 'core conditions' (empathic understanding, unconditional positive regard, and congruence) are necessary and sufficient for therapeutic personality change (1960s and 1970s).

Throughout the controversy over Eysenck's findings, Rogers (1957) developed his own hypothesis for the necessary and sufficient conditions for therapeutic personality change. The central conditions included the therapist's congruency and the client's experience of empathic understanding and unconditional positive regard from the therapist. This hypothesis became an important part of the responses to Eysenck and stimulated a number of studies. Roger's hypothesis continued to be supported through the 1970s (Lambert, DeJulio and Stein, 1978; Truax and Mitchell, 1971) and into the 1980s (Orlinsky and Howard, 1986; Patteson, 1984).

A more recent study by the National Institute of Mental Health compared various treatments for depression (Blatt, Zuroff, Quinlan and Pilkonis, 1996). The treatments included administration of a drug (imipramine), cognitive behavioural therapy, interpersonal therapy and 'ward management' which constituted the placebo. This involved a therapist talking to patients about ward management. The study found no significant differences between the 3 active treatments. The best predictor of a successful outcome was whether the patient perceived the therapist as empathic at the end of the second interview, and not the type of therapy received. This was perhaps one of the more interesting findings that the patient's perception of the therapist was more important than the treatment received.

Category 3: Psychotherapy is for better or for worse (early 1960s)

This was a question initially posed by Truax and Mitchell (1971) whilst reviewing Rogers' hypothesis. Therapists who were scored highly on the 'core conditions' were found to be related to positive outcome and conversely, those therapists scoring lower on the conditions were related to client deterioration. This strongly opposes Eysenck's assertion that no psychotherapy is as effective as psychotherapy. In other words, there are certain factors within the process of therapy which have an effect on outcome, both positive and negative. For example, Bergin (1971) concluded that whilst the past 40 years of research have demonstrated a modestly positive effect, there are certain processes which occur in therapy which are either unproductive or harmful. Lambert, Shapiro and Bergin (1986) also indicated that some therapists could actually be detrimental, which is reflected in some outcome data. Bozarth and Schneider (2000) comment that despite this negative finding, the interest in this area virtually disappeared with the surge of interest for 'specificity' studies in the 1980s and 1990s.

Category 4: The core conditions are necessary but NOT sufficient for therapeutic personality change (late 1970s and early 1980s).

Following research into Roger's hypothesis, 3 main conclusions were drawn. Firstly there are many complex interactions and relationships which exist between therapists, patients, and techniques than first thought. Secondly, the relationship dimensions are not sufficient in themselves for patient change, and thirdly the conditions specified by Rogers are not sufficient, nor necessary, although they can be described as facilitative (Stubbs and Bozarth, 1994).

Some research provided ambiguous conclusions for Rogers' hypothesis. There was a view that further investigation was warranted and some of the designs and theoretical formulations previously adopted were criticised. For example, Bozarth (1983) and Watson (1984) believed that the core conditions had not been adequately investigated. Parloff, Waskow and Wolf (1978) concluded, "more complex relationships exist among therapists, patients, and techniques" (p273). A number of issues were left unresolved. Beutler, Crago and Arismendi (1986) cited these as the need to find, "an acceptance of an optimal level of therapeutic skill, common methods of measurement, and the creation and control of the facilitative skills" (p276). There was a view that the core conditions were 'nonspecific' and similar to placebo effect (Luborsky, Singer and Luborsky, 1975; Shapiro, 1971) and that the conditions are neither necessary nor sufficient, although are facilitative (Gelso and Carter, 1985). It would appear that there was little evidence for such arguments.

Others (e.g. Herbert Benson, 1997) have written about the importance of the placebo effect in all therapies. This view is in accordance with the work by Scott Miller and colleagues, which will be discussed later in this section.

Bozarth and Schneider (2000) argue that there was almost no support for the category of the conditions being necessary but not sufficient. The research shifted towards examining 'specificity', but this was not based upon previous research.

Category 5: There are specific techniques that are uniquely effective in treating particular disorders (late 1980s and 1990s).

Further research into Roger's hypothesis of the necessary and sufficient conditions virtually stopped in the middle 1980s. Studies on client-centred therapy and the conditions therapy theory were no longer of interest. After the middle 1980s, only a dozen outcome studies which emphasised therapists' empathy and were based on Rogerian hypothesis were produced, although all were positive (Sexton and Whiston, 1994). Such research included a study of therapist variables that found that emotional adjustment, relationship attitudes and empathy were most predictive of effective therapists (Lafferty, Beutler and Crago, 1989). Constructs such as 'understanding and involvement' were linked to positive therapy outcome (Gaston and Marmar, 1994); similarly 'warmth and friendliness' was also associated with positive outcome (Gomes-Schwartz, 1978). The one consistent finding, even in this category, is that the therapist variables of empathy, congruence and unconditional positive regard remain common in the efficacy research and are effective. However, despite such findings it was the equivocal reviews of the research on the attitudinal conditions that changed the direction of the research towards 'specificity' of treatment. This replaced inquiry on Rogers' hypotheses and on common factors in general.

Conclusions of psychotherapy research

It would seem that despite the vast amount of research conducted over the past 50 years, many researchers have failed to build upon previous findings. Research is less concerned with core conditions, often viewing them as either supportive or part of

the working alliance. Instead, research continually strives to answer the 'ultimate question' concerning specificity posited by Paul (1967), which asked:

> "*What* treatment, by *whom*, is the most effective for *this* individual with *that* specific problem, and under *which* set of circumstance?"
> (Paul, 1967, p111)

This question was emphasised in the 1970s and dominated research throughout the 1980s and 1990s (Stubbs and Bozarth, 1994). However, the one unaltered, unified and coherent finding is the commonality and effectiveness of therapeutic variables of empathy, congruence and unconditional positive regard (Stubbs and Bozarth, 1994). Further, Duncan and Moynihan (1994) following an independent review of psychotherapy outcome research, concluded that the major operational variable is that of intentionally utilising the client's frame of reference. There followed an increase in the literature of an identification of the common factors of relationship and client resources as being the basis for most psychological improvement (e.g. Assay and Lambert, 1999; Duncan, Hubble and Miller, 1997).

1.2.4 The Effectiveness of Psychotherapy

The research conducted over the past 50 years falls mainly into one of two designs, one proving more popular than the other and consequently shaping the conclusions drawn from the research. The two research designs are efficacy studies and effectiveness studies. However these approaches address different questions and

therefore require different designs. Efficacy studies question whether a particular treatment is effective for a specific condition. Effectiveness studies aim to demonstrate the effectiveness of a treatment as it is applied in daily clinical practice (Chiesa and Fonagy, 1999, p259). Traditionally the efficacy study has been more popular with researchers, for reasons which will be explored.

The growing trend within health care, both in the UK and USA, has been towards evidence-based practice. Various National Task Forces have set criteria against which the status of psychological interventions are measured (Woody and Sanderson, 1998). The USA has developed regularly updated lists of empirically supported psychological treatments (EST) for specific target populations. The UK has differed slightly in that its aim has been to develop clinical guidelines and training which are consistent with the evidence base. For example, within Scotland, the Scottish Intercollegiate Guidelines Network (SIGN) is continuing to develop for almost all areas of mental health. The gold standard for these guidelines has been the randomised-controlled trial and meta-analyses of similar designs.

This 'gold-standard' of research depends upon a number of factors being in place within the research design. Seligman (1995) highlights a number of 'niceties' which will be found in the ideal efficacy study. These include patients randomly assigned to treatment and control conditions. The control conditions include patients who receive no treatment and placebos where all potentially therapeutic ingredients credible to both the patient and the therapist are used to control for influences such as rapport, expectation of gain and sympathetic attention (dubbed nonspecifics). The

treatment under scrutiny is manualised, from which the therapist can not stray. Patients are seen for a fixed number of sessions, often with a follow-up appointment at a specified time. Those involved in rating outcome are blind to which group the patient comes from. Generally the inclusion criteria are strict. The patients themselves meet the criteria for a single diagnosed disorder, and those with multiple disorders are excluded. Often the exclusion criteria will out number the inclusion criteria.

With such rigorous standards, researchers can be confident that following such a design, if a treatment is shown to be different from the controls the result is taken seriously by both academics and clinicians. These findings have then been used within clinical standards and clinical guidelines. Such findings over the years have included the merits of cognitive therapy, interpersonal therapy and medications in the treatment of depression; that transcendental meditation relieves anxiety; that systematic desensitisation relieves specific phobias; that cognitive therapy is effective in the treatment of panic disorder; and so the list continues.

Bohart, O'Hara and Leitner (1998) argue randomised clinical trials have become **the** empirical strategy. The goal being to "demonstrate a clear-cut linear efficient-causal relationship between application of the treatment and alleviation of the disorder" (p144). However, hidden within this are a number of assumptions. Firstly it assumes that it is the treatment that "does the work" and not the individual therapist or the therapeutic relationship. This assumption denies the paradoxical effects and idiosyncratic responses which often occur with new treatments.

Secondly it assumes all those people who share the "same disorder" can be treated in the same manner. These assumptions are keeping in line with the 'specificity myth'. As Bohart et al (1998) assert, this infers that psychotherapy is a relatively straightforward linear-causal affair. A patient's problem can be specified in advance (according to such manuals as the DSM-IV); a treatment is then chosen in accordance with the diagnosis; and the therapist applies the relevant therapeutic manual to treat the problem. If only therapy were so simple and straightforward!

Such an assumption excludes all that makes us human and individual. It does not account for external influences such as relationships, occupation or finances, which can often have a profound effect on an individual in many different ways. Similarly internal influences such as a person's perceived locus of control, motivation and general health can also impact on therapy and outcome.

These assumptions are, in part, the result of external pressures on psychotherapy. The healthcare setting has a considerable influence on how psychotherapy is to be delivered. In the USA where healthcare is paid for through health insurance, the insurance companies will only consider diagnoses that are listed in the DSM-IV and will pay for treatment that has been shown to be effective. Therefore they favour time-limited specific therapies. In the UK, clinical governance is beginning to have an influence on psychotherapy practice and health trusts will want to provide treatments that are both cost-effective and have a strong evidence-base.

However as many therapists will recognise such assumptions and designs do not fit quite so well with day-to-day clinical practice. If the exclusion criteria from randomised controlled trials were to be applied to general adult clinical psychology waiting lists, the numbers could be reduced dramatically as very few people would meet such rigorous standards. Seligman (1995) argues that the main problem with efficacy studies is that they exclude too many crucial elements of what is actually done in the field. It therefore does not reflect psychotherapy as it is actually practised in daily life.

Seligman (1995) reports 5 properties which characterise psychotherapy as it is actually done. He argues that if these properties are important to patient's improving, efficacy studies will underestimate or even miss the value of psychotherapy as it is actually done.

1. The first is that psychotherapy is very rarely of fixed duration. It usually continues until the patient is improved or until they terminate therapy. Efficacy studies, on average, provide 12 sessions and then stop, regardless of how the patient is doing.
2. Psychotherapy is self-correcting. This refers to the therapist's ability to switch between techniques and modalities, if one technique is not working. Efficacy studies, on the other hand, are often limited to a small number of techniques, within one modality.
3. Patients often arrive in psychotherapy after active shopping for a specific treatment. This may be more apparent in the USA than the UK, but the patient may have chosen between various mental health professions and individuals

when engaging in psychotherapy. Alternatively, many may have failed to respond to previous therapies or therapists but respond well to another therapist. As Bozarth and Schneider indicate there is evidence for the adverse effect of 'psychonoxious' therapists. Within efficacy studies, patients are randomly assigned to treatment.

4. Close examination of an average therapist's caseload will probably reveal that most patients do not fit neatly into one, single, diagnosable DSM-IV or ICD-10 disorder. Rather, the majority of patients tend to have multiple problems and psychotherapy is designed to relieving parallel and interacting difficulties.
5. Psychotherapy is also designed towards improving the general functioning of patients as well as a specific symptom or disorder. Efficacy studies usually focus on one specific symptom or disorder.

Given the numerous variances within psychotherapy it may be difficult to imagine how scientific research could be undertaken. However Seligman (1995) argues that the effectiveness of treatment can be empirically validated, but requires a very different method. The method he advocates is large-scale surveys of the consumers of psychotherapy. The Consumer Reports (CR) in its 1994 annual questionnaire included a survey about psychotherapy. It included a section about mental health which respondents were asked to complete if applicable. Of the 22,000 who responded, 7,000 responded to the mental health question. The result was some very rich information about psychotherapy. A sample of the findings from this survey were as follows:

- Treatment by a mental health professional usually worked.
- Of the 426 people who felt 'very poor' at the beginning of therapy, 87% were feeling 'very good, good or at least so-so' by the time of the survey.
- Long-term therapy produced more improvement than short-term therapy.
- There was no difference between psychotherapy alone and psychotherapy plus medication for any disorder.
- All mental health professionals appeared to help their patients; psychologists, psychiatrists, and social workers did equally well and better than marriage counsellors.
- Active shoppers and active clients did better in treatment than passive recipients. This was determined by the response to the question, "Was it mostly your idea to seek therapy?"
- No specific modality of psychotherapy did any better than any other for any problem. Seligman (1995) argues this confirms the 'Dodo Bird' hypothesis that all forms of psychotherapies do about equally well. This is contrary to efficacy researchers who seek to demonstrate the usefulness of specific techniques for specific disorders.

This method addresses many of the difficulties associated with efficacy studies, mentioned earlier. Advantages of this method included that although the sample was perhaps not representative of the United States as a whole, it was believed to be representative of the middle class and educated population who make up the majority of the psychotherapy patients. CR sampled all treatment durations from one month or less through two years or more. This is distinct from efficacy studies which are of

a fixed treatment duration. The majority of respondents reported more than one problem and many were thought to be 'sub-clinical', as their problems would not fit DSM-IV criteria for any disorder. There were therefore no exclusion criteria. The sample surveyed reflected the people who attend for psychotherapy in the US.

Seligman (1995) argues the main advantage of this method is its realism. Psychotherapy is assessed as it is actually performed and many of the findings are reflective of previous findings in psychotherapy research. However Seligman concedes that as it is not a well-controlled, experimental study it does have some flaws. These include the sampling method, lack of a control group and that rating is not performed blind, or double-blind. It is possible the sampling is biased as it may be only those who succeeded in treatment who responded. There is no control group so it is unclear whether talking sympathetically with friends or allowing time to pass would produce just as much of an improvement. The CR survey did not ask those who only talked to friends or the clergy to complete the questionnaire. However there are a number of internal controls including the finding that marriage counsellors do significantly worse despite there being no difference in kind of problem and severity or duration of treatment. Also it was found family doctors do significantly worse than mental health professionals when treatment continues for more than 6 months. The survey is not double-blind, or single-blind, there were no psychometric outcome measures, and the outcome measures used were poorly normed. The respondents reported retrospectively which is less valid than a concurrent observation.

The CR study has many advantages over the efficacy studies, but also has a number of flaws. Its main strength is that it captures how and to whom treatment is actually delivered, within actual clinical practice. It provides a powerful addition to what we already know about the effectiveness of psychotherapy in that it perhaps allows more detailed observations of the therapeutic process. However, the main disadvantage of effectiveness studies is its limit to answering the question, "Can psychotherapy help?" Where efficacy studies, by controlling for as many variables as possible, can argue that a particular type of treatment is successful in treating a particular diagnosis, effectiveness studies can not. All they can argue is that psychotherapy does better than something else, such as doing nothing at all; it usually returns people to normality; and people generally have fewer symptoms and a better life after therapy than before.

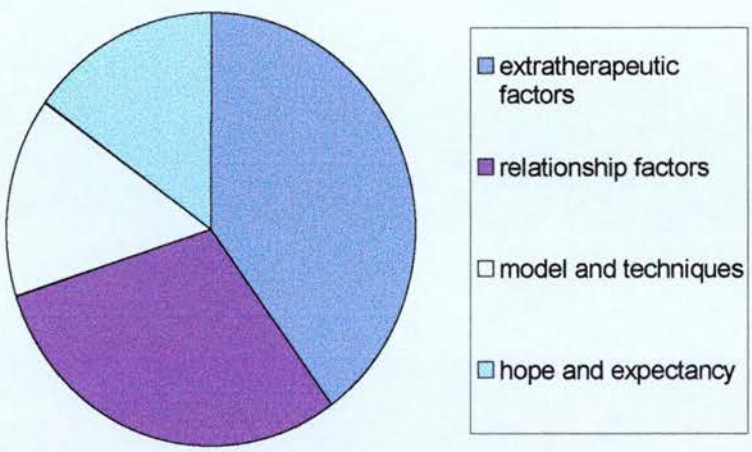
This being said, there can still be important findings observed and explored within effectiveness studies, as the following section highlights.

1.2.5 What Works?

Lambert et al, (1986) suggested 30% of outcome variance is accounted for by the common factors (defined as variables found in various therapies, regardless of the therapist's theoretical orientation). Forty percent of the variance is accounted for by the extra-therapeutic change variables (factors that are part of the client and his or her environment that aid in recovery, examples being relationship changes, financial changes or occupational changes). Bozarth and Schneider (2000) summarised in their paper that the clear message from over 50 years of outcome research is that the

relationship between the client and the therapist in combination with the resources of the client respectively account for 30 and 40% of the variance in successful psychotherapy. Techniques account for 15%, comparable to 15% success rate related to placebo effect. These proportions are illustrated in figure 1.

Figure 1 What works in Therapy



Source: Institute for the Study of Therapeutic Change: What Works?

www.talkingcure.com/whatworks.htm

This view is supported by Hubble, Duncan and Miller (1999). Hubble et al (1999) assert that since the mid-1960s there has been a dramatic increase in the number of therapy models from 60 to more than 250. However, the research throughout this period has consistently found that the various treatment approaches are effective, but achieve roughly the equivalent results. This result is the same for biological

treatments, cognitive and cognitive behavioural treatments. However there is still a tendency to develop new and allegedly 'different' models for specific disorders. The evidence strongly suggests that the differences between the models cannot be held accountable for the effectiveness of treatment. Rather it is the similarities rather than the differences, which can account for their effectiveness (Hubble et al, 1999).

From the research, Hubble et al (1999) identified 4 common factors, which have emerged to account for 'What Works' in therapy. These are as follows:

1. extra-therapeutic (including the client and chance-change producing events)
2. relationship
3. placebo, and
4. model and technique.

The amount each factor contributes towards therapy is illustrated in figure 1.

Hubble et al compare 'What Works' to eating a pie. They assert the main ingredient in a pie is the filling, and there is little point in eating a pie without the filling. Eating pie without the filling is like trying to do therapy without the client, without depending on the client's resources and experiences. The second most important factor is the relationship, or in the pie metaphor, the crust or container for the pie's filling. The relationship contains the client whilst allowing their resources to take centre stage. The crust enhances the importance or unique qualities of the filling. The pie's visual presentation and aroma represent the placebo factors. These factors include the aspects of change accounted for by the client's knowledge of being in treatment and hopes for improvement. Finally, the model or technique used by the

therapist can be thought of as the meringue or frosting, or as the authors describe it "nothing but fluff". That is to say what the therapist uses is devoid of any value without the rest of the pie. It is useful, but it is not crucial to what works in therapy.

1.2.6 Summary

The work of Bozarth and Schneider, Seligman and Hubble, Duncan and Miller, emphasises the importance of effectiveness studies. They raise concerns about efficacy studies which are used to determine what treatments are available. It is argued that effectiveness studies are more relevant for informing on clinical practice and concerns are raised that if the findings from efficacy studies are rigorously implemented, therapy could be curtailed. Such concerns include the increasing trend towards time-limited therapy. This often conflicts with therapists' instincts to offer as many sessions as is felt necessary, but is favoured by health trust officials for the potential cost benefits.

Perhaps the main difference between efficacy and effectiveness studies is their approach to the non-specifics in therapy. Efficacy studies view them as confounding variables, whereas effectiveness studies view them as treatment variables. Such studies are interested in how these variables interact, or co-vary with one another, rather than trying to tease them out of the therapy equation. There is a conscious use of the extra-therapeutic factors in effectiveness studies.

It is perhaps more accurate to state that efficacy and effectiveness studies are asking two distinct questions about psychotherapy and the confusion or conflict between the two arises from this not being made clear at the outset. Efficacy studies can inform whether a new form of therapy is effective in the treatment of a certain disorder in highly controlled, scientific conditions. Effectiveness studies inform as to what is actually done in the field and what actually works in therapy. It is such an approach that is more pertinent to this study.

1.3 THE THERAPEUTIC ALLIANCE

1.3.1 Introduction

The therapeutic alliance is an important non-specific factor which is often not actively pursued in efficacy studies. However the move within psychotherapy research in the 1990s has been towards focussing on both the **process** as well as the outcome of treatment. Gaston (1990) argues the fundamental aim of research has become an increasing interest in understanding the mechanisms of change. Within this search for what the components of psychotherapy are, the importance of theoretically relevant and clinically useful concepts has frequently been stressed (Kiesler, 1985). There are few process variables within psychotherapy for which there exists substantial research evidence for both their existence and worth.

It has been argued the key factor of the psychotherapy process is the alliance. The Therapeutic Alliance is considered by many to be the most important common factor in psychotherapy and may be responsible for the Dodo Bird effect (Henry, Strupp, Schacht and Gaston, 1994). Wolfe and Goldfield (1988) viewed the alliance as the quintessential integrative variable because its importance is recognised across different theoretical orientations and is not specific to one school of thought. It emerged primarily from psychodynamic and client-centred traditions, but has been increasingly recognised in other approaches such as cognitive and behavioural (e.g. Bordin, 1979) and also in pharmacotherapy (e.g. Docherty and Feister, 1985).

Despite the fact the alliance has been one of the most intensely studied non-specific factors in psychotherapy research, it still lacks a single, clear definition (Henry et al, 1994). This lack of clarity has impeded the progress in understanding more fully the role of the alliance (Frieswyk et al, 1986). In addition there exists considerable doubt about the validity of the alliance concept (Gaston and Marmar, 1994). This chapter will examine the numerous different definitions which exist and the subsequent instruments which have been devised to measure the alliance. The functions and properties of the alliance will be explored with particular focus on the alliance's association with outcome in therapy. The final section will explore the concept of the therapeutic alliance, as it will be used within this study, with reference to the Session Rating Scale revised by Johnson (2000).

1.3.2 Definitions of the Alliance

Interpretations of the patient-therapist relationship have traditionally been the main focus of psychodynamic psychotherapy. However, this relationship is not isolated and analytic thinkers have recognised the patient-therapist relationship as a central component in the process of therapy (Henry et al, 1994). The alliance as a clinical construct was first termed by Freud (1912), however empirical research did not begin until the mid 1970s (for reasons which will be explained in the following section). Freud commented upon both the transference (the neurotic aspects of the client's attachment to the analyst) and the friendly, positive feelings the client has towards the therapist. Further, Freud believed the positive, reality-based components of the relationship provided the basis for a therapeutic partnership, or alliance, against the

common foe, the client's neurosis (Freud, 1958). Freud (1912/1966) in his early theoretical papers on transference, differentiated between the realistic, collaborative aspects of the therapeutic relationship and the more distorted ones (Gaston, 1990). He believed the patient's affectionate feelings towards the therapist originated in the non-conflicting, trusting elements of relationships with parental figures. This then formed the basis of the patient-therapist collaboration. Freud described the "friendly and affectionate aspects of the transference which are admissible to consciousness and which are the vehicle of success" (Freud, 1912/1966, p105).

In line with Freud's earlier ideas, Zetzel (1956) introduced the term 'Therapeutic Alliance', referring to the patient's attachment to and identification with the analyst. The term refers to the affectionate aspects of the therapeutic relationship. Zetzel compared the therapeutic alliance to the positive aspects of the mother-child relationship. She did not define the concept of the therapeutic alliance, but discussed its technical implications for success in psychoanalysis.

Sterba, on the other hand, offered one of the first definitions of the alliance in 1934. Sterba (1934) used the term 'ego alliance', referring to the patient's capacity to work in analysis. The ego alliance emphasised the need for an alliance between the reasonable aspects of both the therapist and the patient. He believed the patient's capacity to work in psychoanalysis was critical for its success. Further, the patient needed to be able to oscillate between experiencing and observing in order to work in analysis. This alliance stemmed from the patient's mature ego functioning and partial identification with the working style of the analyst (Gaston, 1990).

This type of alliance was later labelled 'working alliance' by Greenson who first used the term in 1965. Greenson reported that the working alliance stems from the patient's mature ego functioning and partial identification with the working style of the analyst. He recommended that the analyst actively differentiated between the patient's realistic reactions to the treatment situation, or alliance, and the internal misperceptions of the therapist, or transference. Greenson viewed the alliance as consisting both of the patient's affectionate feelings toward the therapist and the patient's capacity to work in therapy (Gaston, 1990). This definition therefore refers to the working aspects of the therapeutic relationship with the focus on the patient's contribution (Henry et al, 1994). Rather confusingly, Greenson used the terms working alliance and therapeutic alliance interchangeably. This has led to some theoretical confusion as the terms emphasise different aspects of the therapeutic relationship (Dickes, 1975).

The term therapeutic alliance as used by Zetzel (1956) is similar to Luborsky's (1976) Type 1 helping alliance. Luborsky identified two types of therapeutic alliance. Type 1 is based on the patient experiencing the therapist as both supportive and helpful. This is consistent with the formulations of Rogers (1951) who emphasised the importance of empathy, warmth and genuineness of the therapist (Salvio, Beutler, Wood and Engle, 1992). Type 2 alliance is based on a sense of working together in a joint struggle against what is impeding the patient (Salvio et al, 1992). This framing of the alliance is similar to Bordin (1979) who proposed the therapeutic alliance consists of 3 related components. Firstly, the client and therapist are in agreement on the goals of treatment. Secondly, the client and therapist are

agreed on the tasks to achieve these goals. Thirdly, there is the development of a personal bond between the client and therapist. This reframed the alliance construct in broader, pantheoretical terms (Horvath in Horvath and Greenberg, 1994).

Gaston (1990) attempted to pull together the variety of definitions by proposing that the alliance is a multidimensional construct, composed of 4 relatively independent dimensions. These include the working alliance, or patient's capacity to purposefully work in therapy; the therapeutic alliance of patient's affective bond to the therapist; the therapist's emphatic understanding and involvement; and the patient-therapist agreement on the treatment goals and tasks.

Despite the variations between definitions, as Gaston and Bordin have demonstrated, there is a general consensus on the central ideas of the alliance. This study is concerned with the therapeutic alliance. The therapeutic alliance, as opposed to the working alliance, is concerned with the partnership, or collaboration in achieving the goals of therapy. This is achieved by combining Rogers' (1951) original thinking about the therapist-provided conditions with the client's contributions (Marmar et al, 1986). There is a move from what the therapist does to promote change (i.e. Rogers' core conditions of empathy, respect and genuineness) to what occurs when the therapist and client work together to achieve the goals in therapy. A summary of the main definitions of the therapeutic alliance and the terminology used is provided in Table 1.

Table 1 Summary of the Definitions of the Therapeutic Alliance

Name	Date	Term used	Definition
Sterba	1934	Ego Alliance	The need for an alliance between the reasonable aspects of both the therapist and the patient.
Zetzel	1956	Therapeutic Alliance	The patient's attachment to and identification with the analyst; the affectionate aspects of the therapeutic relationship.
Greenson	1965	Working Alliance	Consists of both the patient's affectionate feelings toward the therapist and the patient's capacity to work in therapy.
Luborsky	1976	Helping Alliance (Type 1)	The patient experiences the therapist as supportive and helpful.

1.3.3 Measurement of the Alliance

Despite the numerous definitions regarding the alliance it is generally accepted that it does exist. One of the main difficulties, and an area which has been studied over the last 30 years, is that of measuring the alliance. Given the many different theoretical definitions of the alliance, each with its own particular emphasis, a wide range of alliance measures have developed over the last 30 years. Historically there has been a lack of interest in the psychotherapeutic process before 1976. Prior to this period, researchers had not studied the area due to the lack of familiarity with the concept of

the alliance and lack of reliable measures available. It was not until the mid 1970s that researchers became interested in the 'inner workings' of psychotherapy.

The research developed following an emerging interest in the nonspecific factors (Frank, 1961). That is, factors not uniquely associated with a specific form of intervention. However as Horvath (1994) argues, this is a confusing term as there is a difference between non-therapy related variables, for example expectations and attention, and factors specific to therapy, but available to some degree in all therapies. Therefore a more useful term would be generic variables. Further, the finding that overall, different therapies produced comparable client improvements (Luborsky et al, 1975) propelled interest in to the area.

The first attempt to measure the alliance was designed by Luborsky (1976) and was rated by clinical judges. Subsequent attempts used both patient and therapist ratings. Most instruments used today are available as both a self-report measure and as an observer's rating scale (Horvath, 1994). However, Tichenor and Hill (1989) argued that these forms of rating do not necessarily coincide. From their research, it was shown that there was little agreement between clients, therapists and observers on what working alliance was. Bachelor (1992) demonstrated significant differences between therapist and client ratings across several instruments.

Between the late 1970s and early 1980s, a number of instruments were developed independently and more or less simultaneously to measure the alliance. Horvath

(1994) describes 5 clusters of instruments which have been used in the majority of the research. They are categorised as follows:

1. The California Psychotherapy Alliance Scales (CALPAS/CALTRAS; Marmar, Horowitz, Weiss and Marziali, 1986)

Marmar et al (1986) reported on the Therapeutic Alliance Rating System (TARS) which consisted of 41 questions, rated by clinical judges. They hypothesised 4 alliance dimensions: patient's positive and negative contributions; and therapist's positive and negative contributions. Marziali (1984) developed parallel forms of the TARS so that patients, therapists and clinical judges could rate alliance. A principal component analysis revealed two dimensions to the alliance: a total positive contribution, and a total negative contribution (Marmar et al, 1986). Marmar, Weiss and Gaston (1989) further examined the psychometric properties of the original TARS and renamed the measure the California Psychotherapy Alliance Rating System (CALTARS). Fifty-two bereaved patients were treated in brief dynamic psychotherapy and the CALTRAS was rated by 2 clinical judges on four 30-minute segments of therapy sessions. Following analysis, 5 components were retained of which 3 reflected the theoretically defined dimensions of the alliance (Patient Commitment reflecting the therapeutic alliance, Patient Working Capacity reflecting the working alliance, and Therapist Understanding and Involvement) and 2 negative dimensions (Patient Hostile Resistance, and Therapist Negative Contribution).

Marmar, Gaston, Gallagher and Thompson (1989) extended the concept of the alliance as measured by the CALTRAS to include Bordin's (1979) theoretical view

that the main components of the alliance includes agreement on goals and tasks. The revised scale was named the California Psychotherapy Alliance Scales (CALPAS). It was completed by both the therapist and the patient in a clinical trial of depressed elderly patients treated in behavioural, cognitive, or brief dynamic psychotherapy. The therapist version items were highly correlated, indicating a single alliance dimension. The patient version items were analysed and 5 components were identified. Four were consistent with theoretical considerations. Patient Commitment, or the Therapeutic Alliance, is consistent with Freud's early papers on transference and further work by Zetzel who introduced the term therapeutic alliance. Patient Working Capacity, or working alliance, reflects Sterba's (1934) writings. Therapist Understanding and Involvement, reflects the component argued by Bowlby (1988) and Rogers (1957) who asserted that the therapist plays an important role in forging the alliance in psychotherapy. Finally, Disagreement on Goals and Strategies was based on Bordin's (1979) definition of the alliance. The fifth component reflected the therapist's negative contribution to the alliance.

The current version of the CALPAS is a 24-item questionnaire designed to assess 4 dimensions: Patient Commitment, reflecting the 'therapeutic alliance'; Patient Working Capacity, or the 'working alliance'; Therapist Understanding and Involvement, reflecting the therapist's contribution to the alliance; and a Working Strategy Consensus, reflecting the agreement on goals and tasks of therapy.

2. Penn Helping Alliance Scales (PEN/HAQ/HAcs/HAr; Alexander and Luborsky, 1987)

The Penn scales developed from Luborsky's large-scale study of psychodynamic therapies (the Penn Psychotherapy Project). As detailed above, Type 1 alliance and Type 2 alliance were identified. Later versions of the scale use a global rating method. The Penn Helping Alliance Scale consists of 10 Likert-style items. Two judges rated the Penn for the 10 most and 10 least improved patients treated in brief psychodynamic psychotherapy. A correlation of 0.91 was found between the two scales' scores, which suggested that only one alliance dimension could be detected (Gaston, 1990).

3. Therapeutic Alliance Scale (TAS; Marziali, 1984a)

Indicated in the subscales, the TAS was developed to measure both positive and negative alliance factors. The alliance components include Patient's Positive Contribution, Therapist's Positive Contribution, Patient's Negative Contribution, and Therapist's Negative Contribution.

4. Vanderbilt Psychotherapy Process Scale of Vanderbilt Therapeutic Alliance Scale (VPPS/VTAS; Hartley and Strupp, 1983)

The first empirical study of a measure of the patient-therapist collaboration in psychotherapy was designed by Gomes-Schwartz (1978). A sample of patients with anxiety and depression were treated by psychoanalysts and lay therapists. Two judges rated the Vanderbilt Psychotherapy Process Scale (VPPS), which consisted of

84 Likert-type items, on four 10-minute segments of therapy. Following analysis, 7 related components were detected. Gomes-Schwartz reinterpreted these as reflecting exploratory processes, patient involvement, and therapist-offered relationship. Hartley and Strupp (1983) developed the Vanderbilt Therapeutic Alliance Scale (VTAS). This was developed as a measure specifically designed to assess the alliance. It was examined using the same method as the VPPS. Six factors were yielded from analysis. These scales included the following alliance components: Patient's Participation, Patient's Exploration, Patient Motivation, Patient's Acceptance of Responsibilities, Therapist Warmth and Friendliness, and Negative Collaboration. Hartley and Strupp (1983) viewed these components as reflecting contributions of both the patient and the therapist to the alliance, and of their interaction.

5. Working Alliance Inventory (WAI; Horvath, 1981, 1982)

The Working Alliance Inventory was developed to measure the 3 alliance components described by Bordin (agreement on goals, agreement on tasks and bonds). Analysis indicated a substantial amount of convergence among WAI scales, with the strongest association between the goal and task scales. It was found that obtaining scores on these scales, particularly task, early on in therapy, was predictive of outcome and differentiated between those who dropped out of therapy early and those who remained within therapy (Kokotovic and Tracey, 1990; Plotnicov, 1990). There is some evidence to suggest a moderate to strong correlation between the subscales (e.g. Adler, 1988; Horvath and Greenberg, 1987). However there is one

factor analytic study which supported the 3 scales as distinct (Tracey, Gliden and Kokotovic, 1988).

Relation between Instruments

Given the numerous instruments designed to measure different 'alliances' one question which arises is how much do each of the constructs overlap? Horvath (1994) argues that this can be approached in 3 different ways. Approaching this in a theoretical manner would involve analysing the extent to which the definitions of each instrument are equivalent. An empirical approach would involve estimating the covariance among measures. Or, finally, researchers could investigate whether all these measures predict outcome equivalently.

Horvath, Gaston and Luborsky (1993) examined the differing definitions and found there to be 2 aspects of the alliance common to each of the instruments: (a) personal attachments or bonds, and (b) collaboration or willingness to invest in the therapy process. In addition, some of the related concepts were evident in 2 or more instruments. For example, participants' positive and/or negative contributions to therapy are measured in both the CALPAS and the TAS. Shared or mutually determined goals for the session are measured in the CALTRAS, WAI and PEN. A positive attitude toward the belief in the efficacy of the in-therapy tasks is measured in the CALTRAS and WAI. However Horvath does highlight that the weight or emphasis given to each component varies among each measure.

Adopting a more empirical approach, Tichenor and Hill (1989) compared 3 observer-rated instruments and the client and therapist versions of the WAI. They discovered a 12% to 71% overlap among 3 observer-rated scales (PENN, VTAS, and WAI-observer). Adler (1988) reported 34% variance overlap between the clients' ratings and 9% overlap between the therapists' ratings of the WAI and the HAQ. Only a handful of studies have been conducted to assess the actual overlap and so little can be concluded from these mixed findings.

The final approach is difficult as there is no single instrument which could be considered the best predictor of outcome in therapy. There is also evidence that not all outcomes are equally well predicted by each measure (e.g. Adler, 1988; Greenberg and Adler, 1989). However it is unclear whether the differences are due to the different demands of each therapeutic approach or to differential sensitivity of the measures (Horvath, 1994).

At a global level, it would seem the overlap across measures supports the case that each is assessing a related underlying construct. As there is little consensus as to the constituent elements of the alliance then it is evident that lower between subscale correlations would be expected. Horvath (1994) asserts that there is evidence of a basic consensus at the coarsest level of analysis, or by defining the alliance in global terms.

1.3.4 Reliability and Properties of the Alliance

Horvath and Symonds (1991) conducted a meta-analysis of the alliance. From a review of the literature, they found 34 studies using different alliance instruments. The average reliability of alliance measures was .86. They found the therapist rated measures to be most reliable (r = .93, based on 5 studies) and that client's scales were also stable (r = .88, based on 13 studies). A further meta-analysis was conducted by Martin, Garske and Davis (2000). In this paper, 79 studies met the inclusion criteria. The research was conducted over an 18-year period, 49 studies were available between 1990 and 1996. The overall average reliability of the alliance scales was .79 (N = 93, SD = .16).

Further analysis revealed in both meta-analyses that the length of time in treatment did not have an effect on the alliance and outcome, and similarly type of treatment also did not have an effect on the alliance and outcome. It would seem that the alliance is both a reliable measure and is independent from a number of treatment variables.

There is still little known about the basic properties of the alliance (Piper, Boroto, Joyce, McCallum and Azim, 1995). One issue is whether and how the alliance varies over time. Another is whether patterns of change are related to therapy outcome. Henry et al (1994) reported from differing studies which point to both its stability in one set and its variability in another. Mann (1973) suggested a curvilinear, high-low-high pattern over 12 sessions, time-limited therapy. Miller et al (1983) reported a similar pattern.

1.3.5 The Role of the Alliance

Gaston (1990, p148) in her review of the literature highlighted 3 major roles which could be adopted by the alliance in psychotherapy. These were hypothesised as follows:

1. "The alliance as being therapeutic in and of itself."

This emerges from the work by Rogers (1957) and his model of client-centred psychotherapy. He argued (as described in chapter 1) that the therapeutic relationship represents a necessary and sufficient ingredient for therapeutic change to occur. Some have argued that the alliance development, for some patients, is therapeutic in its own right. For example Frieswyk et al, (1986) suggested that for patients who present with important interpersonal deficits, the development of an alliance constitutes a therapeutic achievement as it improves the quality of interpersonal relationships outside of therapy. Similarly Balint (1968) has written on the developmental function of the therapeutic relationship. Therapist interventions are regarded as tools to be employed to promote the development of a patient-therapist alliance. Gaston (1990) argues that one way of testing this hypothesis would be to determine whether the alliance could predict outcome over and above the therapist's technical ability.

2. "The alliance as being a prerequisite for therapist interventions to be effective."

It is generally acknowledged now that the alliance is necessary, but not sufficient, for successful psychotherapy. Rather, the alliance is regarded as a prerequisite for the efficacy of therapist interpretations. The alliance allows the patient to work actively with the interpretations provided by the therapist, and helps the therapist to

elaborate more adequate interventions (Freud, 1912/1966; Greenson, 1965). Therefore the alliance does not uniquely contribute to the acquisition of therapeutic benefits, but acts as a mediator between the therapist's interpretations and the context within which the therapist interventions promote change.

3. "The alliance as interacting with various types of therapist interventions, exploratory versus supportive, for determining success in psychotherapy."

Zetzel (1956) proposed that for patients who presented with difficulties in establishing a good-enough alliance, supportive strategies might be more helpful, rather than an exclusive focus on exploratory interventions. Balint (1968) also reported that for some patients, whose problems are evident at an earlier, developmental stage, interpretation carries a certain risk in that it can leave them feeling rejected by the therapist. Balint (1968) argued that more supportive interventions could prove to be more useful in such cases. This hypothesis suggests the alliance can be viewed as interacting with 2 types of therapist interventions, exploratory versus supportive, in determining outcome.

1.3.6 The Relation between Alliance and Outcome

The relationship between the strength of the alliance and positive therapeutic outcome is well documented (e.g. Horvath and Symonds, 1991; Luborsky, 1990). Horvath and Symonds (1991) conducted a meta-analysis of 24 studies on the alliance and concluded there was a reliable association between working alliance and positive therapy outcome. This relation has been shown to be independent from sample size and length of treatment (Horvath, 1994). The meta-analysis found the alliance

accounted for moderate amounts of outcome variance, with an average effect size of .26. Horvath (1994) argued that this is perhaps a conservative estimate due to the large number of dependent variables measured, but not reported in a number of the studies. He argues that the true value of the effect size is more likely to be closer to .32. This is based on a 95% confidence interval which estimated the region of the true value of the average effect size, which produced a range of .2 - .32. Horvath stated that as the original figure is overly conservative, a more exact figure would lie to the top end of the range, hence the revised figure of .32. However within the meta-analysis the variance among results was greater than expected by chance alone. Therefore the results could have been influenced by a number of factors, for example the time the alliance was assessed, or the type of outcome measure administered.

Martin et al (2000) reported an overall weighted alliance-outcome correlation as .22 ($N = 68$, SD = .12). Again it was argued this could be a conservative estimate, as the effect sizes were not always reported. The authors concluded that the meta-analysis provided more support for the moderate relation between alliance and outcome.

The alliance has been examined in a variety of psychotherapies; for example dynamic (Barber, Critis-Christoph and Luborsky, 1990); experiential (Gomes-Schwartz, 1978); behavioural and cognitive (Gaston, 1991); and group psychotherapy (Gaston and Schneider, 1992). The alliance-outcome association has also been tested in pharmacotherapy (e.g. Gaston, Wisebord and Weiss, 1992). Over the years, the amount of research within this field has grown. Standard designs on alliance-outcome research include the use of residual change scores. This outcome

measure controls for pre-therapy level of the outcome variable. Alliance measures tend to be administered early in therapy (e.g. Kokotovic and Tracey, 1990) or averaged across sessions (e.g. Marmar, Weiss and Gaston, 1989).

Given the available research on the association between the alliance and outcome, and the evidence that it is independent from a number of variables, it suggests that there is something quite important about the relationship between the therapist and the patient. This relationship is independent from the theoretical orientation which the therapist may follow or particular 'treatment of choice'. This adds further credence to the work by Lambert and Hubble and colleagues who suggested relationship factors were more important than treatment model.

However, the alliance-outcome research is hindered by a lack of clear theoretical statements which link the two together. The available research addresses only the 3 general classes of alliance-outcome relationship discussed earlier: the alliance being therapeutic in and of itself; the alliance being a prerequisite for therapist interventions to be effective; and the alliance interacting with various types of interventions for determining success in psychotherapy.

1.3.7 The Session Rating Manual

As outlined previously, there are numerous definitions and measures regarding alliance. However it has been argued that whilst there are differences and problems surrounding the alliance, generally it has been established as both reliable and valid

within psychotherapy research. This study uses the term therapeutic alliance and has implemented the Session Rating Scale (SRS) (Johnson, 2000) to measure the therapeutic alliance. A copy of the SRS is available in the appendix (Appendix 4).

When designing the SRS, Johnson used Bordin's (1979) conceptualisation of the alliance as comprising 3 components; the bond between therapist and client, agreement on goals, and agreement on tasks. Therefore the scale comprises 4 rationally derived subscales. The first scale is the common factors item, questions 1 to 4. These items measure the factors that go with the necessary conditions for change; acceptance, liking, understanding, and honesty. The second scale is the agreement item, questions 5 and 6. The third is smoothness and depth of therapy, questions 7 and 8. The fourth scale is a global item of hope, questions 9 and 10.

Therapeutic Alliance can be measured at different stages in the therapeutic process. Some research favours early measures (e.g. Kokotovic and Tracey, 1990), whereas others measure alliance later on in therapy (e.g. Gaston, Marmar, Gallagher and Thomson, 1990). The SRS was designed so that it can be used at every session. A meta-analysis by Horvath and Symonds (1991) suggested that the values for measuring the alliance early in treatment (first to fifth session) and late (at or near the end of therapy) are nearly identical. However given the time-scale for this study it was decided to measure the alliance after the third session. There is some suggestion in the literature that most improvement takes place by the third session, although the content of the therapy was not being controlled for in this study.

There are a number of advantages that the SRS has over some of the other alliance measures. Firstly it is rated by the patient, which has been shown to be a reliable predictor of the alliance (e.g. Martin et al, 2000). Johnson (2000) also states that asking the patient to complete such a questionnaire demonstrates that their perceptions are valued and are important. It invites the patient into a partnership with the therapist about the sessions. (However it was not being used in such a manner in the present study.) It is also a short questionnaire, comprising 10 items which are rated on a 4-point scale. It is relatively easy and quick to complete, increasing the likelihood of compliance. It also covers the main factors (common factors, agreement items, depth and hope) described by Hubble et al (1999). Although at this stage there are few studies published using this measure it is increasingly being used by the main researchers in the field in the USA, and data is being generated. The psychometric properties of the SRS are described in the Method.

Of interest to this study are the findings that firstly therapeutic experience does not predict a strong therapeutic alliance (e.g. Dunkle and Friedlander, 1996). Therefore the SRS can be administered equally by trainees and qualified clinical psychologists. Secondly, the literature also suggests the model of therapy does not have a significant impact on the alliance (e.g. Salvio, Beutler, Wood and Engle, 1992). Therefore although the SRS originates from a solution-focussed theoretical background this should not influence the measure.

1.3.8 Summary

As research has focussed more on the process of therapy, one factor which has continually been highlighted as important, if not essential to therapy, is the therapeutic alliance. A term first used by Freud, and emerging predominantly from the psychodynamic field, the alliance has encountered numerous definitions and measures over the past 30 years. It could be argued that most of the definitions which exist have a shared comprehension of the alliance, and that any differences are minimal. Research on the alliance has consistently shown its positive association with therapeutic outcome and meta-analyses have confirmed both its reliability and validity.

The present study favoured a relatively new measure of the alliance, devised by Johnson in 1995 and revised in 2000. It was devised using Bordin's (1979) conceptualisation of the alliance, encompassing 3 components; the bond between therapist and client; agreement on goals; and agreement on tasks.

1.4 SOLUTION-FOCUSSED THERAPY AND PRE-TREATMENT MEASURES

1.4.1 Introduction

The first section of this chapter examined the factors which contribute to what works in therapy and in particular the relative importance of each of the common factors. Factors such as hope and expectancy were reported to account for 15% of what works in therapy and relationship factors accounting for 30% (Hubble et al, 1999). Some of the findings reported by people such as Hubble, Duncan and Miller, emanate from their observations of therapy using solution-focussed techniques. They have emphasised the importance of not just the techniques that they use but how the common factors of therapy contribute towards improvement.

This section will focus briefly on the development of Solution-Focussed Therapy (SFT) and examine the techniques specific to it. This will be followed by some of the research which has been conducted to date concerning the techniques of SFT. Some of the questions this research has highlighted will be outlined in relation to this study. Finally, this section will detail the Solution-Focussed Intake Form which has recently been developed and will be used in this study.

1.4.2 Solution Focussed Therapy

The practice of Solution Focussed Therapy has grown considerably over the past 15 years. Therapy itself developed from three different disciplines; psychology,

medicine and philosophy. Each concerned with different elements of therapy; explaining, diagnosing and understanding human nature. Therapy came to involve deliberate attempts to produce a change in viewpoint and/or action leading to a solution. Traditionally, therapy looked to the individual's childhood and past in order to understand the problems. Then in the 1960s, therapies such as behaviour, gestalt and family concentrated more on the here and now in order to help the client. Therapy has since evolved beyond this to a future orientation, concentrating much more on how problems can be solved and interventions to achieve this. It is argued that this relies less on diagnosis or theory, but focuses upon strengths and abilities (O'Hanlon and Weiner-Davis, 1989).

Milton Erickson was a seminal figure in hypnosis, family therapy, brief therapy and strategic therapy. Practising between the late 1920s and the late 1970s he was unusual for his era. The predominant school of therapy over this period was psychoanalytic psychotherapy and much later behaviour therapy. Erickson however used his own brand of therapy, which was both brief and unique. He used no theory of psychopathology; he spent little time concerned with the origins of problems and helped people to change by turning their difficulties into assets. His work had significant influence upon a range of therapies and therapists, some more reputable than others. One of the more reputable therapies is solution-focussed, or solution oriented, therapy.

Perhaps one of the main features that exists within the practice of SFT is that it works very much idiosyncratically. SFT also works with the therapeutic alliance.

The focus of therapy is to generate hope and expectancy; working with what the client brings to therapy; and looking towards solutions. It would be difficult to manualise the work carried out in SFT as it is so dependent upon what the client brings to therapy, listening to the narrative and working with it. For that reason it would be difficult to conduct a randomised-controlled trial of SFT. However, some authors have expressed concern that SFT is being reduced to a set of techniques and in the process, is losing sight of its implicit values and ideology.

1.4.3 Solution-Focussed Techniques

SFT focuses upon the client's strengths, what works, and the positive atmosphere of their therapy (Beyebach, Morejon, Palenzuela and Rodriguez-Arias, 1996). There are a number of techniques pertinent to SFT. Some of the main techniques and the related research follows.

- Solution-talk

One of the techniques advocated in solution focussed therapy is the use of 'change-talk' or 'solution-talk' (de Shazer, 1988; 1994). This involves the therapist asking the client about such things as pre-treatment improvement, that is, what has improved for the client between the time they were first referred and the time of the initial appointment. Other examples of solution-talk include asking clients about the differences between problem and non-problem times, and expressing optimism that the client's situation will improve.

There is evidence that when therapists used solution-talk, the clients often responded by talking about improvement in their situation (e.g., Gingerich, de Shazer and

Weiner-Davis, 1988). Solution-talk was not originally used until later in therapy, which led to interest in what effect it could have on therapy if used at an earlier stage. One study discovered that the more a client used solution-talk in his or her initial sessions, the more they were likely to continue in therapy. In addition, the more clients talk about solutions, or goals in the first session, the more likely they are to complete treatment (e.g. Shields, Sprenkle and Constantine, 1991). Given the demands on current services within the NHS, and the amount of clinical time wasted to non-attenders, such potential for improving efficiency can not be ignored.

- The Miracle Question

SFT has also advanced the use of other techniques including 'The Miracle Question', which enables the client to focus on their goals for treatment, and help them focus upon doing something different to accomplish their goals. The clients also feel more hopeful about their situation after answering the miracle question (Odel, Butler and Dilman, 1997). Clients who have received SFT report that the relationship with their therapist is more important, and more valued, than any specific techniques (Shilts, Rambo and Hernandez, 1997). This would suggest that there is something implicit about this type of therapy that is conducive to the development of a strong therapeutic alliance.

- Pre-treatment Improvement

As mentioned earlier, a technique used by solution-focussed therapist is to ask about pre-treatment improvement, or change. If pre-treatment improvement is reported the client and therapist will spend time discussing how this improvement was achieved.

This can produce 2 advantages within therapy. Firstly it helps the client to identify what steps to take to continue helping their situation, and secondly it enables clients to feel encouraged as they realise their situation can improve.

There is a body of evidence which shows pre-treatment improvement is relatively common. Lawson (1994) reported 51 out of 82 clients reported some from of pre-treatment change. Allgood, Parham, Salts and Smith (1995) found 30% of 200 clients in family therapy reported pre-treatment improvement. Johnson, Nelson and Allgood (1998) reported 53% of clients reported pre-treatment changes.

It has been argued that such improvement can have both theoretical and practical implications (Allgood et al, 1995). Weiner-Davis, de Shazer and Gingerich (1987) argued that clients who believe pre-treatment changes have occurred may have already begun the process of therapy, and of achieving what they want from therapy. Further, once people report a small, positive change, they are more likely to feel optimistic and confident about tackling other problems and consequently increase motivation within therapy (O'Hanlon and Weiner-Davis, 1989). Asking about difference sets the expectation of change that can indirectly increase motivation (Berg and Miller, 1992).

Encouraging hope, confidence and motivation may also help to keep clients in treatment and reduce the chance of them dropping out of therapy. 'Drop-outs' and non-attendance make for an inefficient and ineffective service. It wastes both time and money. Attempting to identify the factors which contribute to unplanned

termination has become an increasingly important area to study. Examples of such factors studied include age (Lowman, DeLange, Roberts and Brady, 1984); ethnicity (Acosta, 1980); and previous treatment (Gaines and Stedman, 1981). Past research has shown that client motivation may be one factor which predicts unplanned termination (e.g. Gaines and Stedman, 1981).

Allgood et al, (1995) reported that in their study client's unplanned termination could be predicted with 76% accuracy. The main contributory factors were the number of sessions and a lack of pre-treatment improvement. Similarly, Johnson et al, (1998) found that clients who reported pre-treatment improvement, and where this was utilised by the therapist, were more likely to complete therapy.

- Presuppositional Questions

This type of questioning communicates a belief or expectation, often concerning changes or improvements the client has made. This helps the client recall and discuss their strengths, abilities and successes. When asked presuppositional questions, clients are more likely to report pre-treatment improvements (e.g. Weiner-Davis et al, 1987).

From the research that has been conducted to date, many questions arise including how does pre-treatment change affect the process and outcome of therapy? What differences exist between clients who do and do not report pre-treatment change? (McKeel, 1999)

In brief, the literature suggests that some of the solution-focussed techniques, for example focussing upon pre-treatment improvement or the miracle question, may have an effect on the therapeutic alliance. In addition, attendance at therapy and outcome may also be positively affected by such techniques.

Unfortunately, there is little research in this area, especially in the UK, and relatively few out-patient programmes have been evaluated. In an era of clinical governance it is important techniques from therapies such as SFT are properly researched and any steps which can improve the effectiveness and efficiency of the process of therapy are adopted.

It is also becoming increasingly common for clinical psychology departments to send out questionnaires to patients prior to treatment. Often the choice of questionnaire is determined by individual preferences, cost of the questionnaire and ease of availability. Therefore it could be argued that if a questionnaire helps to facilitate attendance and therapeutic alliance, which would subsequently influence outcome, then it would be a useful tool in psychotherapy. This study aims to explore such a possibility.

1.4.4 Solution-Focussed Intake Form

The questionnaire employed in this study is the Solution-Focussed Intake Form, an instrument used by Andrew Taylor in the United States and available on the Institute for the Study of Therapeutic Change web site (www.talkingcure.com). The

questionnaire is designed to address some of the factors believed to be important in therapy. The questionnaire divides in to 2 sections. The first asks the client about particular strengths in each of the following areas; home, work, emotion, social and attention. There are 32 questions in total with 5 possible responses. The second section gathers qualitative data about other supports, sources of stress, current functioning and goals in therapy. It also asks the client how many sessions they think they will need. The form therefore captures many of the important aspects highlighted above. It facilitates the client completing the form, prior to therapy, what their strengths are, what their goals are and how long they think they will need in therapy.

However as the questionnaire was designed for a North American population, some items or wording were believed to be unsuitable for a UK population. It was therefore modified within the adult Clinical Psychology department, Tayside by one of the clinicians to account for the cultural differences (both versions are available in Appendix 1 and 2).

The second questionnaire chosen for this study was the Symptom Checklist-90-R (Derogatis, 1994). This questionnaire is a more symptom, or pathology, focussed questionnaire and has been used in a number of studies on the therapeutic alliance (e.g. Piper et al, 1995; Price and Jones, 1987; and Tingey et al, 1996). It was felt that the completion time for both questionnaires was comparable. Further information regarding both these measures is available in the Method, Chapter 2.

1.4.5 Summary

Solution focussed techniques, by emphasising clients' strengths, appear to facilitate the development of a good therapeutic alliance, generating hope and motivation. Some of the main findings from research into SFT techniques include the finding that when therapists use solution-talk, their clients are more likely to talk about change and that the more clients talk about change, the more likely they are to complete therapy. It has also been observed that pre-treatment improvement is relatively common. Further, 'presuppositional questions' usually help the client to notice their strengths and improvements and 'miracle questions' help clients to focus on their goals and to feel more optimistic about their situation. Generally, clients who feel more optimistic and motivated are more likely to complete therapy.

Within the area of SFT there are relatively few questionnaires available to research but the Solution-focussed Intake Form appeared to be the most easy to access and use. The SCL-90-R was employed as the comparable questionnaire which focuses exclusively upon symptoms.

1.5 Summary of Main Research findings

Of particular interest to both researchers and clinicians is discovering what is effective in psychotherapy, and deciding how this can be judged. Over 50 years of psychotherapy outcome research has indicated that various treatment approaches that are available are effective, but achieve roughly the equivalent results. This would suggest that it is the similarities rather than the differences between the models that may account for their effectiveness in therapy. Most studies conducted can be described as specificity research, but these are perhaps based on a number of misconceptions. Effectiveness studies have an important role in research as they reflect clinical practice and inform on what makes therapy successful.

It has been found that the extra-therapeutic factors account for the most variance (40%) in terms of what works in therapy. Common factors and non-specific factors are frequently identified as the important aspects within the therapeutic process. Perhaps the most important common factor within psychotherapy is the therapeutic alliance.

The therapeutic alliance has been shown to be positively associated with therapeutic outcome. This finding is consistent and has been well established in the literature. It has also been shown to be a reliable and valid construct. Numerous definitions and measures exist, but generally they are all identifying similar aspects of the relationship between the patient and the therapist. The therapeutic alliance has been shown to be independent from a number of variables, including diagnosis, severity, length of time in treatment, type of treatment and experience of the therapist.

Solution-Focussed techniques have been shown to make therapy effective. There is evidence that reporting pre-treatment change early in therapy increases the chance of completing therapy and not dropping out. Dropouts within therapy make the service inefficient. Solution-focussed techniques have also been shown to increase patient's motivation and confidence about finding solutions to their difficulties.

Given the current available research a number of questions remain. Research has shown a number of variables which do not influence the therapeutic alliance, but what does have an influence on it? Solution-focussed techniques, used within therapy, have been shown to increase motivation and attendance. However by administering a solution-focussed questionnaire prior to treatment, can motivation to attend be increased, and can the therapeutic alliance be positively influenced?

1.6.1 AIMS AND HYPOTHESES

1.6.1 Aims

The therapeutic alliance is an important, central component in therapy, but few studies have focussed on what effects it. The present study explored whether administering different types of questionnaires, prior to treatment, can have an impact on it. Also, as non-attendance at therapy is very expensive for the health service, the study examined whether administering a solution-focussed questionnaire had an impact on attendance at the first 3 sessions in therapy compared to a pathology focussed questionnaire. A second aim of the study was to determine whether administering a solution-focussed questionnaire prior to starting therapy would have a positive effect on the therapeutic alliance compared to administering a pathology focussed questionnaire.

Previous research has suggested that the Therapeutic Alliance is independent from patient severity. Therefore the study also looked at whether ratings on the pre-treatment questionnaire were unrelated to the Therapeutic Alliance. There is also equivocal evidence as to whether patient-rated measures are more accurate than therapist-rated measures. The study also examined whether there was a relationship between measures rated by patients and therapists.

1.6.2 Hypotheses

Hypothesis 1

Administering 2 different kinds of questionnaire prior to treatment will have an impact on attendance at therapy. In particular, administering a solution-focussed questionnaire compared to a symptom-focussed questionnaire will have a more positive impact on attendance at the first 3 sessions.

Hypothesis 2

There will be a positive relationship between patients' rating of severity, measured by the symptom and solution-focussed questionnaires, and therapists' rating of patient severity, measured by the Global Assessment of Functioning (GAF).

Hypothesis 3

Administering 2 different kinds of questionnaire prior to treatment will have a differential impact on the therapeutic alliance compared to no questionnaire.

- In particular, administering a solution-focussed questionnaire will have a positive impact on the therapeutic alliance when compared with administering a symptom-focussed questionnaire.
- Administering a solution-focussed questionnaire will have a positive impact on each of the subscales of the therapeutic alliance, as measured by the Session Rating Form;

- Common factors
- Agreement items
- Smoothness/depth
- Hope

Hypothesis 4

There will be no difference in relationship between severity, as rated by the symptom and solution-focussed questionnaires, and global score on the Therapist Alliance measure.

CHAPTER 2 : METHOD

2.1 DESIGN

The study employed a between-participants design where participants were randomly allocated to one of 3 groups. The groups were distinguished by type of questionnaire received prior to treatment. Group 1, the 'Symptom-Focussed' group, received a symptom-focussed questionnaire; group 2, the 'Solution-Focussed' group, were sent a solution-focussed questionnaire; and group 3 was the control group, receiving no questionnaire prior to treatment. Therapeutic Alliance was measured for each group at the 3rd treatment session.

Ethical approval was sought and obtained from the Tayside Committee on Medical Research Ethics. Minor changes were requested for the patient information sheet, but no changes were made to the research design.

2.2 PARTICIPANTS

The criterion for inclusion in the study was patients who were referred to the Clinical Psychology department and offered an appointment after the 1st July 2000. The criterion for exclusion from the study was patients who had been re-referred during the time period.

All new patients offered an appointment between the 1st July 2000 and 1st June 2001, at an adult out-patient Clinical Psychology department in Tayside, were asked to participate in the study. Patients were referred mainly by their GP (92.42%) and the majority were female (59.18%). In total, 414 new appointments were offered during

the research period. The available demographic information on this cohort is provided in table 2.

Of those who attended for first appointment, 127 consented to the study, 49 (38.6%) were male and 78 (61.4%) were female. The demographic information on the subjects who did not consent to the study ($N = 287$) is provided in table 3.

Table 2 Demographic Information on all Patients sent an Appointment

Gender	40.82% male 59.18% female
Mean Age	39.34 years SD = 12.65 Range = 17 – 86 years
Source of referral	92.42% GP 4.55% Psychiatrist 3.0.3% Other[1]
Mean Waiting Time	34.41 weeks SD = 35.28 Range = same week – 160
Location seen	64% GP 28.7% psychology department 7.3% Cottage Hospital

[1] 'Other' referrals included Social Work and Practice Counsellors

Table 3 Demographic Information on patients who did not consent

Gender	41.8% male 58.2% female
Mean Age	38.74 years SD = 34.94 Range = 17 – 72 years
Source of referral	94.6% GP 2.5% Psychiatrist 3% Other
Mean Waiting Time	35.38 weeks SD = 34.94 Range = same week – 160
Location seen	68.7% GP 25.3% psychology department 6 % Cottage Hospital

2.3 THERAPISTS AND TYPE OF THERAPY

All therapists in the Clinical Psychology department were involved in the study. In total, 5 qualified Clinical Psychologists (average years of experience was 11.6) and 2 Trainee Clinical Psychologists (a first year trainee and a final year trainee) took part in the research. Treatment was offered as usual and therapists were unaware which group their client had been assigned to.

Therapists' behaviour was not being controlled for and was therefore a potentially confounding variable. However most of the therapists use a wide variety of skills rather than one particular therapeutic orientation.

2.4 MEASURES

The measures used in this study included the Symptom Checklist-90-Revised (SCL-90-R)(Derogatis, 1994), the Solution Focussed Intake Form (SFI) (Taylor, unpublished) and the Session Rating Form (SRS) (Johnson, 2000). The Global Assessment of Functioning (GAF) (American Psychiatric Association, 1994) was another measure used in this study. Within the department it is routinely measured at first and last session, providing an overall score of function.

2.4.1 Symptom Checklist-90-Revised (SCL-90-R)

This questionnaire was originally developed in the 1970s. It is historically related to the Hopkins Symptom Checklist (HSCL) and its prototype was the SCL-90 (Derogatis, Lipman and Covi, 1973). The SCL-90-R is a 90-item, self-report

questionnaire which is designed to reflect the psychological symptoms of community, medical and psychiatric respondents. Each item is rated on a 5-point scale of distress, ranging from 'not at all' to 'extremely'. It is scored in 9 primary symptom dimensions and 3 global indices of distress. The primary symptoms are as follows:

- Somatization,
- Obsessive-Compulsive,
- Interpersonal Sensitivity,
- Depression,
- Anxiety,
- Hostility,
- Phobic Anxiety,
- Paranoid Ideation, and
- Psychoticism.

The global indices are as follows:

- Global Severity Index,
- Positive Symptom Distress Index, and
- Positive Symptom Total.

The SCL-90-R is estimated to take between 12 and 15 minutes to complete.

2.4.2 Solution Focussed Intake Form (SFI)

This measure has been used most widely by Andrew Taylor with patients attending a Psychiatric Clinic in the United States. The origin of this measure is uncertain: Dr Taylor did not develop it but was first introduced to it at a conference on Solution-Focussed Therapy when it was described in a paper presented by "someone" from Canada (A. Taylor, personal communication, April 4 2000). The form has not been published but is available on the World Wide Web (www.talkingcure.com).

This form was revised by a member of the Clinical Psychology department where the research was conducted, in May 2000, for a UK population. The original form is available in the appendix (Appendix 1) as is the revised form (Appendix 2). The original version was 5 pages long and felt to be too lengthy. In addition, many of the sections were not relevant for the purpose of the study. It was hoped clients completing this form would be orientated towards a solution-focussed approach and the sections omitted which covered 'family information', 'problems with coping' and 'problems struggling with', were not anticipated to influence the measure.

Obviously such changes to the original form will have an impact on both the reliability and validity of the measure. However despite extensive literature searches and correspondence with the original authors, information on the reliability and validity of the SFI was not available.

The measure was chosen because there is no other measure that is specifically designed to assess patients' strengths. In spite of its vague origins, it is also being used increasingly by Solution-Focussed therapists.

The form comprises 2 main sections. The first section divides into 5 items which are scored on a 5 point likert scale, ranging from 'rarely' to 'most of the time', and 'not applicable'. The 5 items are as follows:

- Home – 7 questions
- Work – 8 questions
- Emotional – 9 questions
- Social – 8 questions
- Attention – 4 questions

The second section provides qualitative information on support, sources of stress and goals in therapy. For the purpose of this study, this information was not used or coded.

As there was no scoring criteria available for the SFI it was decided by the author to follow the scoring format of the SCL-90-R. Items were scored from 1 to 4, 1 corresponding to 'most of the time' and 4 to 'rarely'. Therefore a higher score indicated more stress, or less coping. This direction is in line with the SCL-90-R. For each subscale items were added and divided by the number of responses in that section. If an item was scored as 'not applicable' it was not given a score and the

number of 'not applicable' items was subtracted from the total number of items in that section.

As the forms were returned it was noted that in a number of questionnaires, the scale 'Work' was scored entirely as 'not applicable'. People who scored this item as 'not applicable' were mainly not working either because they did not work, or because they were unable to work due to their symptoms. This had the potential to distort the global score significantly. It was decided that this item would not be included in the global score. The global score therefore includes the total score for the other 4 items divided by 28 (minus the number of questions to which the response was 'not applicable').

2.4.3 Session Rating Form (SRS)

The original version of the SRS was published in 1995 and used slightly different language for the subscales. For example question 7 was originally entitled "Smoothness of the session" and asked whether, "The session was smooth?" was changed to "Agreement on Treatment" and asks to what extent, "The treatment I received was right for me?" Similarly, question 8 was changed from 'depth' to 'pace' of the session. Both versions of the SRS are available in the appendix (Appendices 3 and 4).

The SRS is still a relatively new scale that has not, to date, been used in any large-scale studies. It was examined with 39 patients in a brief psychotherapy clinic in the western United States (Stanford, 1999). Cronbach's alpha reliability coefficients

were utilised to determine internal consistency. Inter-item correlations were calculated to provide evidence for the existence of subscales. Item analysis provided a Cronbach's alpha reliability coefficient of .89 (Johnson, 2000).

In addition to the global score which this measure provides, there are also 4 subscales, which are as follows:

- Common factor items
- Agreement items
- Smoothness/depth
- Global items of hope

Items are rated from 0 to 4; 4 being more positive, 2 being neutral and 0 being negative. Johnson (2000) states that therapists should be looking for a total score in the neighbourhood of 27 or greater. A score below 27 is indicative of a problem in therapy.

2.4.4 Global Assessment of Functioning (GAF)

The Global Assessment of Functioning (GAF) Scale is found in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM-IV]; American Psychiatric Association, 1994). The GAF is used as a therapist's report of how the patient is functioning. Scores on this scale range from 1 – 100, with higher scores representing better functioning. The score takes into account an individual's symptom severity, social, occupational and family functioning, communication and reality testing, and

danger to self or others. A copy of the GAF is provided in the appendix (Appendix 5).

2.5 PROCEDURE

Subjects were randomly allocated to one of the three groups by the department secretary. All subjects were sent a Patient Information sheet, which detailed the main aspects of the study and what was required from them. This sheet varied slightly for the control group, as they were not required to complete a questionnaire. Copies of the Patient Information sheets are provided in the appendix (Appendix 6 and Appendix 7). All subjects signed the Tayside Ethics Committee standard consent form. A copy of this is provided in the appendix (Appendix 8).

The symptom-focussed group completed the SCL-90-R questionnaire and the solution-focussed group completed the Solution Focussed Intake Form. The control group did not receive any questionnaires. Subjects were asked to return the forms in the pre-paid envelope or bring them to their first appointment.

At the third treatment session, all subjects were asked to complete the Session Rating Form. At the end of the third treatment session, subjects were given the form and a pre-paid envelope. The form could therefore be completed anonymously.

Other information collected on each participant included:

- Source of referral e.g. GP or Hospital Consultant.

- Time between date of referral and date of 1st appointment, i.e. waiting time.
- Where they were seen: GP surgery, Clinical Psychology Department (based in the Mental Health hospital) or a Cottage Hospital.
- Whether they attended at first appointment or did not attend without cancelling.
- Attendance at the first 3 appointments, that is whether they attended for the first 3 appointments or whether they defaulted from treatment during this period.

2.6 ANALYSIS OF DATA

2.6.1 Data Analysis

All statistical analyses were carried out using the Statistical Package for Social Sciences (SPSS) for Windows 95, Version 9. Statistical analyses carried out were a Chi-square to explore categorical differences, correlations to look at relationships between variables and analysis of variance to look at differences between groups.

When using a correlational analysis, Cohen (1988) has suggested the following guidelines as an indication of the strength of the relationship:

$r = \pm .10 - .29$	small
$r = \pm .30 - .49$	medium
$r = \pm .50 - 1.0$	large

These guidelines were employed for all correlational analyses.

2.6.2 Statistical Power

Previous research on the therapeutic alliance has focussed mainly on its relationship with outcome (e.g. Luborsky, 1990). Horvath and Symond's (1991) meta-analysis reported an average effect size of .26. However Hovarth (1994) suggested this was perhaps a conservative estimate due to large numbers of dependent variables not being cited in the research. Therefore an effect size of .32 was estimated. Based on this finding, and according to Cohen (1992), a sample size of 21 per group would allow detection of a large effect size of .30, at $\alpha = .05$, and power of 0.80.

CHAPTER 3 : RESULTS

3.1 EXPLORATION OF DATA

Not everyone who consented to the initial phase of the study responded to the second phase (the completion of the Session Rating Form), the Results section is divided in to 2 sections to reflect the 2 phases of the study. The first part of the Results section will explore the data from the pre-treatment questionnaires and will test Hypotheses 1 and 2. The second part of the Results section will explore the data from the Session Rating Form and test Hypotheses 3 and 4.

Prior to statistical analysis, the data was explored. Where applicable, the data was investigated for distribution. The data was found to be normally distributed and histograms for age, waiting time, mean initial GAF scores, global score on the SCL-90-R and SFI are presented in the appendix (Appendices 9, 10, 11, 12 and 13). Parametric tests were employed because the population variables were normally distributed. Significance was set at the $<.05$ level.

3.2 PART ONE

3.2.1 Demographic Data

Of the 414 patients who were approached to take part in the study, 127 consented to the initial phase of the study. This reflected a response rate of 30.68%. However 4 participants subsequently cancelled their referral, either because they no longer required psychological input, or because they were attending another mental health

professional. Consequently, the total number of participants in the first phase of the study was 123. The demographic data of all that consented is provided in Table 4.

Table 4 Demographic Data – Part One

Gender	38.2% male 61.8% female
Mean Age	40.57 years SD = 14.07 Range = 16 – 86 years
Source of referral	88.6% GP 8.1% Psychiatrist 3.3% Other
Mean Waiting Time	31.68 weeks SD = 35.33 range = 1 – 143 weeks
Location seen	58.5% GP 32.5% psychology department 8.9% Cottage Hospital
Mean GAF score at first appointment Median	58.25 55

Of the 123 who consented to the study, 47 were randomly allocated to the Symptom-focussed group, 47 were randomly allocated to the Solution-Focussed group, and 29

were randomly allocated to the control group. The demographic information as it breaks down for each group is presented in Tables 5, 6 and 7.

Table 5 Symptom-Focussed Group Demographic Data

Gender	16 (34%) male 31 (66%) female
Mean Age	41.11 years SD = 15.45 Range = 16 – 86 years
Source of referral	42 (89.4%) GP 2 (4.3%) Psychiatrist 3 (6.4%) Other
Mean Waiting Time	31.2 weeks SD = 32.23 Range = 1 - 139
Location seen	28 (59.6%) GP 15 (31.9%) psychology department 4 (8.5%) Cottage Hospital
Mean GAF score at first appointment Median	58.46 55

Table 6 Solution-Focussed Group Demographic Data

Gender	19 (40.4%) male 28 (59.6%) female
Mean Age	38.68 years SD = 13.06 Range = 18 – 85 years
Source of referral	42 (89.4%) GP 5 (10.6%) Psychiatrist 0 Other
Mean Waiting Time	33.33 weeks SD = 37.20 Range = 1.86 – 141.71 weeks
Location seen	28 (59.6%) GP 14 (29.8%) psychology department 5 (10.6%) Cottage Hospital
Mean GAF score at first appointment Median	58.32 55

Table 7 Control Group Demographic Data

Gender	12 (41.45) male 17 (58.6%) female
Mean Age	42.76 years SD = 13.38 Range = 21 – 71 years
Source of referral	25 (86.2%) GP 3 (10.3%) Psychiatrist 1 (3.4%) Other
Mean Waiting Time	29.80 weeks SD = 38.10 Range = 1 - 143
Location seen	16 (55.2%) GP 11 (37.9%) psychology department 2 (6.9%) Cottage Hospital
Mean GAF score at first appointment Median	57.78 58

One-Way ANOVAs and chi-square were used to compare the 3 groups on age, source of referral, waiting time, GAF score and gender. There were no significant differences found between the 3 groups in terms of age (F = 0.806; d.f. = 2; p = 0.449), source of referral (χ^2 = 2.26; d.f. = 4; p = 0.688), waiting time (F = 0.095; d.f. = 2; p = 0.909), GAF (F = 0.30; d.f. = 2; p = 0.971) and gender (Chi-square χ^2 = 0.567; d.f. = 2; p = 0.753).

3.2.2 Hypotheses-Related Data

Hypothesis 1

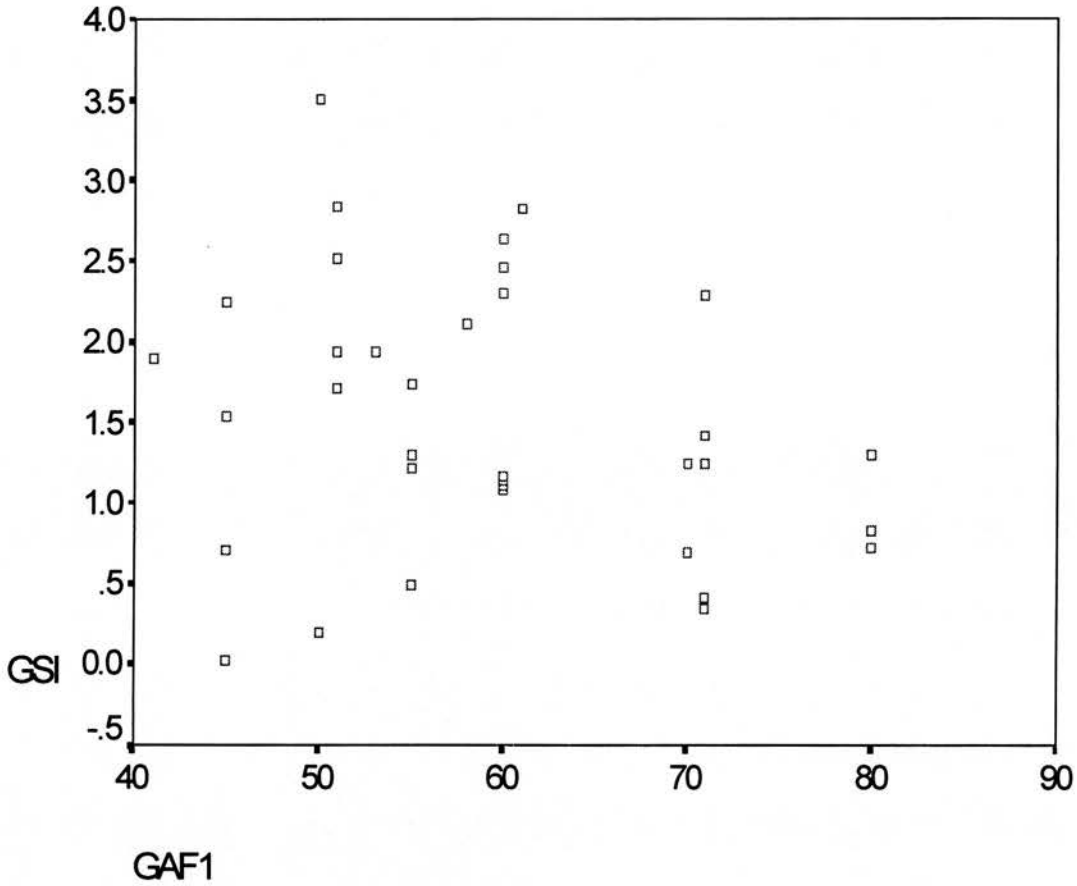
A Chi-Square was employed to test the hypothesis that administering a solution-focussed questionnaire compared to a symptom-focussed questionnaire and no questionnaire, prior to treatment will have a more positive impact on attendance at the first three sessions. No significant difference between the 3 groups on attendance was found (Chi-square $\chi^2 = 0.368$; d.f. = 2; $p = 0.832$).

Hypothesis 2

A Pearson's correlation was employed to test the association between patients' rating of severity, measured by the symptom-focussed and solution-focussed questionnaires, and the therapists' rating of severity, measured by the Global Assessment of Functioning (GAF). A Pearson Product Moment correlation revealed a small relationship between global score on the SCL-90-R and the GAF, which was not statistically significant ($r = -.298$; $p = 0.298$). This is illustrated in figure 2.

A Pearson correlation indicated a large relationship between global score on the SFI and the GAF, which was statistically significant at the 0.01 level ($r = -.503$; $p < .01$). This is illustrated in figure 3.

Figure 2 Scattergram of GAF score and Global SCL-90-R

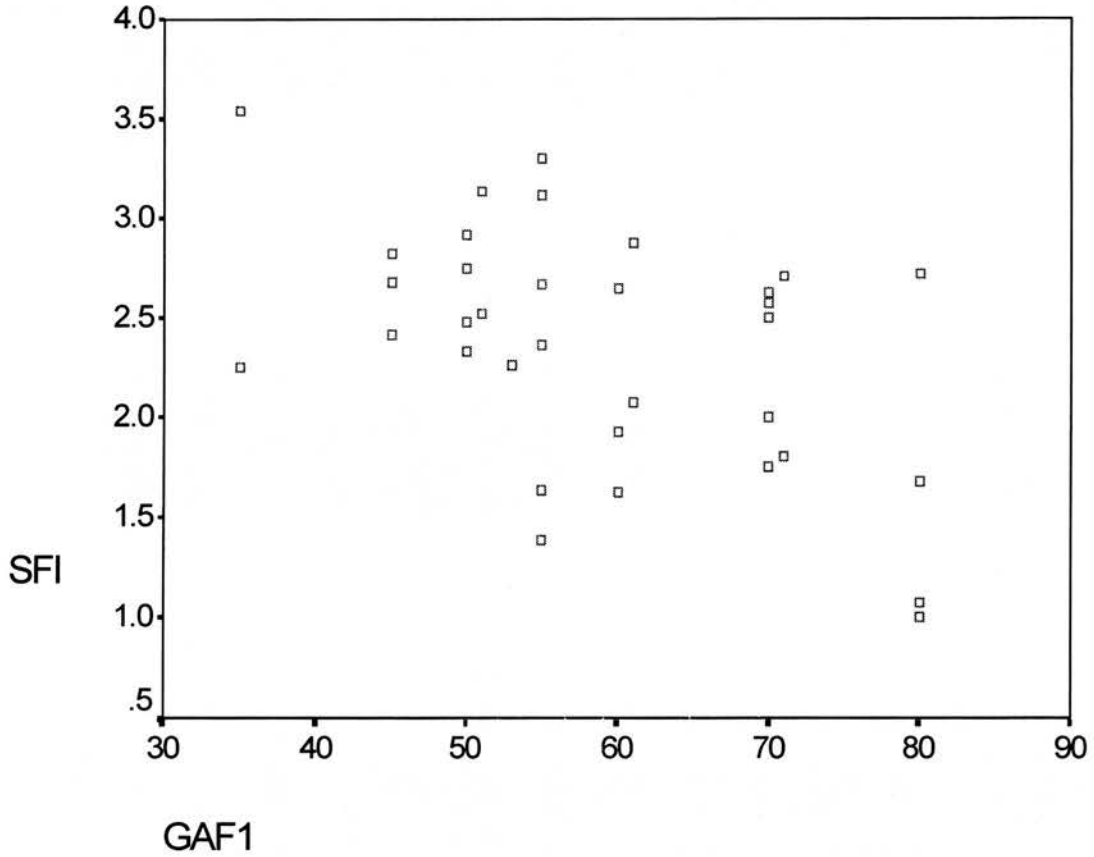


Key

GAF1 = initial GAF score

GSI = global score on the SCL-90-R

Figure 3 Scattergram of GAF Score and Global Solution Focussed Score



Key

GAF1 = initial GAF score

SFI = global score on the Solution-Focussed Intake Form

3.3 PART TWO

3.3.1 Demographic Data

Forty-four participants responded to both parts of the study; that is they completed a questionnaire and/or a consent form, and at third treatment session completed the Session Rating Scale (SRS). The demographic data for this population is provided in Table 8.

Table 8 Demographic Data – Part Two

Gender	17 (38.6%) male 27 (61.4%) female
Mean Age	40.43 years SD = 15.66 Range = 16 – 86 years
Source of referral	39 (88.6%) GP 5 (11.4%) Psychiatrist 0 Other
Mean Waiting Time	32.85 weeks SD = 39.09 range = 1 – 143 weeks
Location seen	20 (45.5%) GP 20 (45.5%) psychology department 4 (9.1%) Cottage Hospital
Mean SRS	37.18

3.3.2 Hypothesis-Related Data

Hypothesis 3

It was hypothesised that by administering a solution-focussed questionnaire, compared to a symptom-focussed questionnaire, there would be a differential impact on the therapeutic alliance. In particular it was hypothesised that a solution-focussed questionnaire would have a more positive impact on the therapeutic alliance than the symptom-focussed questionnaire. No significant difference was found between the 3 groups on the measure of therapeutic alliance (SRS) ($F = 0.241$; d.f. = 2; $p = 0.787$).

It was further hypothesised that administering a solution-focussed questionnaire prior to treatment would have a more positive impact on each of the subscales of the SRS (common factors, agreement items, smoothness/depth and hope), when compared to a symptom-focussed questionnaire and no questionnaire. No significant differences were found between the 3 groups on any of the subscales. The results from the One-Way ANOVA are provided in Table 9.

Table 9 One-Way ANOVA for the SRS subscales

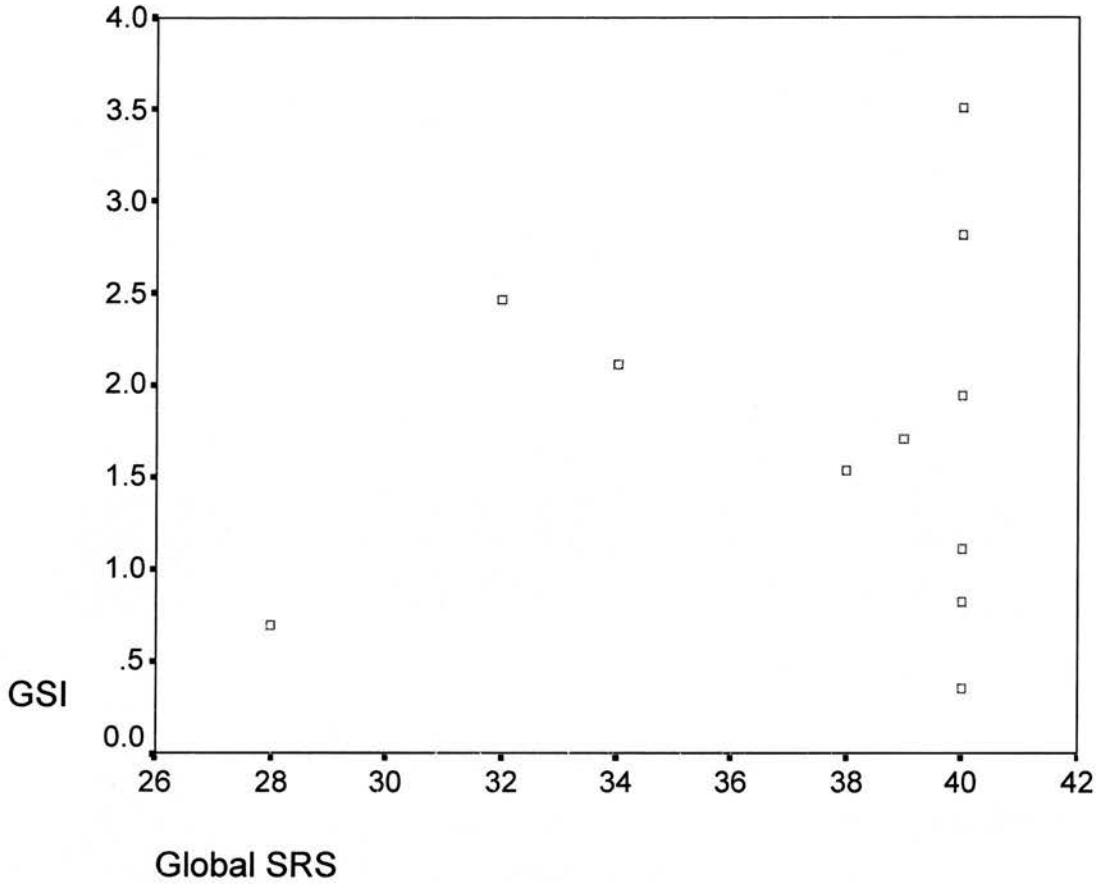
	F	d.f.	Sig.
Common Factors	0.235	2	0.792
Agreement	0.513	2	0.602
Smoothness	0.533	2	0.591
Hope	0.511	2	0.604

Hypothesis 4

Scores of patient severity, measured by the global score on the SCL-90-R and global score on the SFI were hypothesised to be not related to the global score on the SRS. A Pearson Correlation reported a small relationship between the SRS and the SCL-90-R ($r = .121$; $p = 0.724$) and a medium relationship between the SRS and the SFI ($r = -.427$; $p = 0.128$). However neither correlation is statistically significant, as predicted. The relationships between both sets of variables are illustrated in figures 4 and 5.

The amount of shared variance (how far variation in one variable is accounted for by the other) should be calculated when a small sample size is used ($N < 30$) (Pallant, 2001). This was carried out by calculating the coefficient of determination and expressed as a percentage ($r^2 \times 100$). Therefore the amount of shared variance between the SRS and SCL-90-R was 1.46% and the amount of shared variance between the SRS and SFI was 18.23%.

Figure 4 Scattergram of Global SCL-90-R and SRS

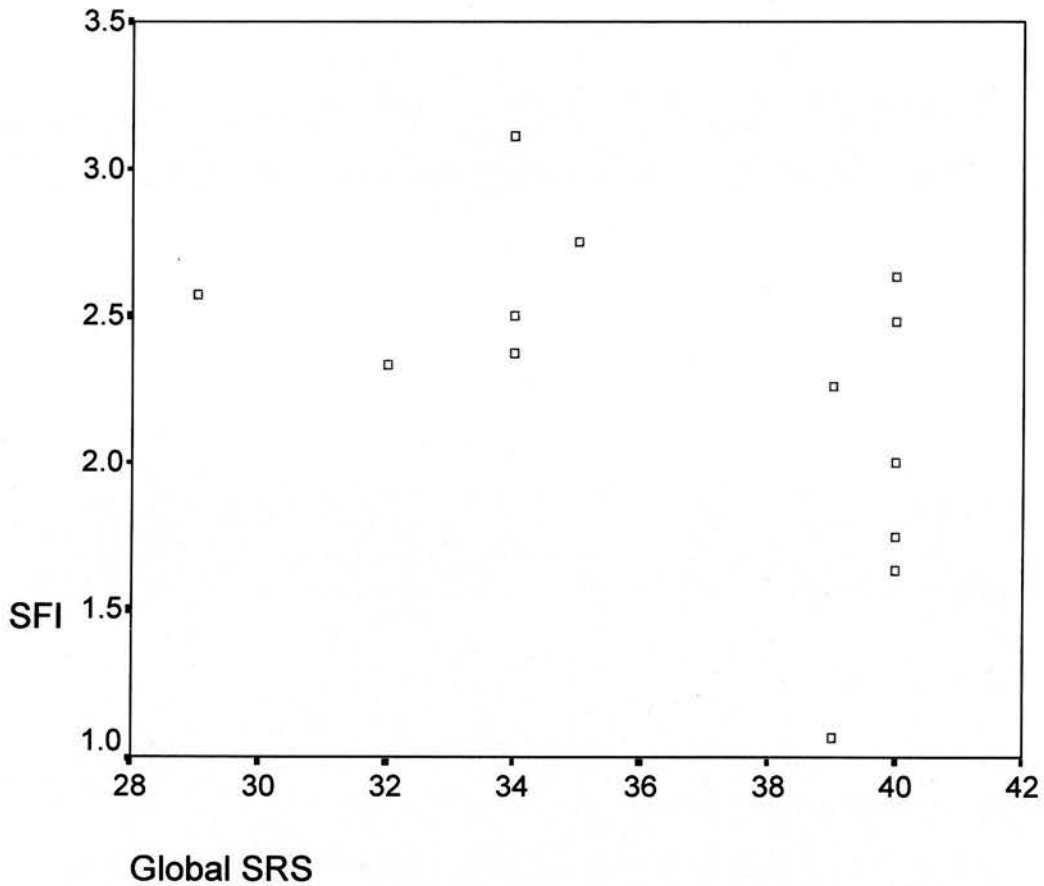


Key

GSI = global score on the SCL-90-R

SRS = global score on the Session Rating Scale

Figure 5 Scattergram of Global Solution-Focussed Score and SRS



Key

SFI = global score on the Solution-Focussed Intake Form

SRS = global score on the Session Rating Form

3.4 SUMMARY OF RESULTS

There were no significant differences found between the symptom-focussed group, the solution-focussed group and the control group on attendance at therapy over the first 3 sessions. There were also no significant differences found between the groups on the global measure of therapeutic alliance (SRS) nor were any significant differences found on the subscales of the SRS. Therefore hypotheses 1 and 3 were not supported in this study and the null hypotheses were unable to be rejected.

Severity on the symptom-focussed questionnaire and on the solution-focussed questionnaire was not significantly related to the SRS. Therefore hypothesis 4 was supported.

There was a significant relationship found between the global SFI score and the initial GAF score. There was not a significant relationship found between the global SCL-90-R score and the initial GAF score.

There are a number of possible reasons for the results found in the study, which will now be discussed.

CHAPTER 4 : DISCUSSION

4.1 SUMMARY OF RESEARCH

It has been suggested in the research by a number of different authors that extra-therapeutic factors and relationship factors account for 40% and 30% respectively, when estimating what actually works in the therapeutic process (e.g. Hubble et al, 1999; Lambert et al, 1986). More recently, there has been an increasing trend within the research field to address such factors and study their influence more closely. One non-specific factor, which has been widely studied in effectiveness research, is the therapeutic alliance. The therapeutic alliance has been considered by many to be the most important common factor in psychotherapy (e.g. Henry et al, 1994).

The research from authors such as Hubble, Duncan and Miller has developed mainly from their work with, and observations from, Solution-Focussed therapy (SFT). They have demonstrated the importance of the common factors in therapy and have also described the importance of a number of techniques. Some research using SFT has suggested the benefits of using particular pre-treatment measures on attendance at therapy and also subsequent completion.

The aim of the study was to evaluate whether using a particular type of pre-treatment measure would have an effect on attendance at therapy and therapeutic alliance, measured after the third session. The study also evaluated the relationship between patient ratings of severity and therapist ratings of severity. The final aim of the study was to evaluate the relationship between the therapeutic alliance score, rated by the patient, and the patient's pre-treatment severity score, as measured by the pre-

treatment questionnaires. Two different types of questionnaires were sent to all new patients offered an appointment at an adult Clinical Psychology Department over a 12-month period. One questionnaire was focussed on symptomatology and the other was a solution-focussed questionnaire. A control group received no questionnaire prior to treatment. From a population of 414, 123 consented to the initial phase of the study, and of this 123, 44 consented to the second phase. It was hypothesised that the solution-focussed group would be more likely to attend and stay in treatment for the first 3 sessions compared to the other 2 groups. It was also hypothesised that the solution-focussed measures would correlate more strongly with the therapist rated scores of severity. For the second phase of the study it was predicted that the solution-focussed group would have a more positive rating on Therapeutic Alliance when compared with the symptom-focussed group. It was further predicted that there would be no relationship between patients' scores on the pre-treatment questionnaires and the therapeutic alliance measure.

4.2 DISCUSSION OF THE RESEARCH FINDINGS

4.2.1 Hypothesis 1

Research into the use of solution-focussed techniques, for example asking clients about pre-treatment improvement or changes, has been shown to have a positive effect on patient motivation and increase the client's confidence to tackle other problems (e.g. Berg and Miller, 1992; O'Hanlon and Weiner-Davis, 1989). It has been hypothesised that clients reporting pre-treatment change have already begun the process of achieving what they want from therapy (Weiner-Davis et al, 1997). It is also possible there has been a cognitive change towards solving problems. Further, research has shown that the use of solution-focussed techniques and particular solution-focussed questionnaires have a positive effect on attendance and completion of therapy (e.g. Allgood et al, 1995; Johnson et al, 1998).

In the present study there was no significant difference found on attendance at the first three sessions of therapy between the group of patients who received a solution-focussed questionnaire prior to treatment and the group of patients who received a symptom-focussed questionnaire. There was also no significant difference between the experimental groups and the control group. Therefore in this study it was found that administering a particular style of questionnaire prior to treatment did not improve attendance at therapy over the first 3 sessions. Similarly, administering a questionnaire prior to treatment did not have an effect on whether patients dropout of treatment over the first 3 sessions. Therefore whilst it has been suggested that

solution-focussed questionnaires may facilitate patient motivation and confidence to tackle problems, within this study there does not appear to have been a difference, in terms of attendance, between the 2 experimental groups.

It may be that for those patients receiving the symptom-focussed questionnaires they felt their symptomatology was being validated. They perhaps derived as much benefit completing such a questionnaire as those asked about solutions and strengths.

Perhaps a more practical explanation for the finding that there were no differences between groups in attendance and dropout is due to the fact that the population analysed was required to give consent to the study. Analysis between those who had consented and those who had not was not possible in this study, as information was only collected on those who had consented. It was only possible to collect basic demographic information on those who had not consented. It would have been useful to have been able to compare attendance rates on those who opted-in and those who did not. However this would have conflicted with the stipulations of the Ethics Committee.

Therefore it is perhaps unsurprising that the dropout rate within the first 3 sessions in this study was very low. Some papers have reported high dropout rates for psychotherapy. In a meta-analysis of 125 studies, an average dropout rate of 47% was reported (Wierzbicki and Pekarik, 1993). This figure is consistent with other studies (e.g. Garfield, 1986), although there have been reports that within time-limited psychotherapy, dropout rates are lower (e.g. Sledge, Moras, Hartley and

Levine, 1990, reported a dropout rate of 32% for brief therapy with a defined time limit). Perhaps by consenting to the study, participants were also consenting to treatment. Having taken the time to complete the questionnaires, consent form and return them, it is probable that such people would be more likely to attend for appointments. However, without comparable data on the two groups it is difficult to assess whether the small dropout rate in the study is reflective of the dropout rate within the population as a whole.

4.2.2 Hypothesis 2

There is equivocal support for the finding that patient and therapist ratings of the patient's severity are highly correlated and valid. There is however little research into whether pre-treatment questionnaires can influence initial presentation at therapy and subsequently therapists' impression of severity. It was hypothesised that a pre-treatment questionnaire would influence a patient's presentation at first appointment as it would orientate the patient towards therapy thus allowing the therapist to more accurately judge their current level of functioning.

There was a significant relationship found between patients' ratings on the Solution-Focussed Intake Form and therapists' ratings on the Global Assessment of Functioning. There was no significant relationship detected between patients' ratings on the Symptom Checklist-90-Revised and the Global Assessment of Functioning. This significant relationship between patients who had completed the Solution-Focussed Intake Form and therapists' rating of severity suggested there was something different in the initial presentation of these patients. However as there

were no significant differences between the groups in terms of age, average waiting time, referral source and GAF score at first session, these variables could not have influenced this result.

A longitudinal study would be required to investigate the causal aspects of this relationship and account for other potential variables. Such variables might include the experience of the therapist and the validity of the GAF. However, this result would suggest that there was something about completing the solution-focussed questionnaire which altered the patient's initial presentation at therapy. This would follow from Weiner-Davis' hypothesis that patients completing solution-focussed questionnaires have undergone some form of cognitive shift towards therapy. It is possible that were there a cognitive shift, a behavioural and emotional change may also occur. Patients may view their situation in a different way following completion of the SFI; they may feel more hopeful about their problems and resourceful about tackling them. However further investigation with both a larger sample and a design which controls for possible confounding variables is warranted before such a hypothesis could be validated.

It would be interesting to examine the patients' perceptions about completing questionnaires; whether they found it useful or helpful, as hypothesised; or whether it altered their beliefs about their problems which were bringing them to therapy. Given the low response rate it would seem most people, given the choice, chose not to complete questionnaires at all. However this area will be discussed in more detail later.

4.2.3 Hypothesis 3

The Therapeutic Alliance is recognised as one of the most important factors in the process of therapy. However how it is influenced is difficult to determine as it has been shown to be independent from a number of factors; for example symptom severity, experience or sex of the therapist, type of therapy and length of time in therapy (e.g. Horvath and Symonds, 1991). It was hypothesised that the type of pre-treatment questionnaire administered prior to treatment could have an impact on the therapeutic alliance. Research in SFT has suggested that solution-focussed questionnaires can initiate a client into therapy, increasing their confidence and motivation (e.g. O'Hanlon and Weiner-Davis, 1989). Such changes could have an influence on the therapeutic alliance measure as it examines factors such as hope, expectancy and agreement on therapy. In this study no significant differences were found on the measure of therapeutic alliance between the 3 groups. Therefore, in this study, it was found that the type of pre-treatment questionnaire administered did not have an effect on the therapeutic alliance.

One possible explanation for this finding is that by the third session, patients were committed to treatment and there had been sufficient time for the therapist's behaviour to influence the therapeutic alliance. Therefore any effect the pre-treatment questionnaire may have had would be lost by this stage in therapy. As the Session Rating Form is examining the different components of the patient-therapist relationship, the therapist's behaviour will have a very strong influence on this questionnaire's score.

Alternatively, given the small sample size for this part of the study it is possible that there was not enough power to detect a difference and that a type 2 error was made. The effect size was calculated for this part of the study and was found to be .01, which according to Cohen (1992) is a small effect size. A re-calculation of power at .80 and $\alpha = .05$, revealed 322 participants would be required in each group for a small effect to be detected (Cohen, 1992).

It is also possible that the finding that pre-treatment questionnaires do not effect therapeutic alliance is correct. As mentioned earlier, therapeutic alliance has been shown to be independent from a number of variables and this study would suggest that pre-treatment questionnaires are another variable from which the therapeutic alliance is independent.

4.2.4 Hypothesis 4

The amount of psychological distress a client experiences does not seem to have an effect, either positive or negative, on the therapeutic alliance (e.g. Martin et al, 2000). Therefore it was predicted that the scores on the SRS would be independent from the scores on the patient-rated questionnaires. That is, regardless of how the patient rates themself on either the SCL-90-R or the SFI, these scores will not have an association with the SRS. It was found in this study that there was no significant relationship between the questionnaires from both the experimental groups and the SRS. The amount of shared variance between the questionnaires and therapeutic alliance measure was small, although it was slightly higher for the SFI and the SRS.

This study would suggest further evidence for the finding that the therapeutic alliance is not affected by patient-rated severity. It would be premature to base any recommendations on these findings alone, however it is interesting that there is more shared variance between the SFI and the therapeutic alliance. This is perhaps suggestive of a small association between the measures. They originate from similar theoretical backgrounds and both are intended to improve the process of therapy. However the amount of variance is small and the numbers involved in this part of the study were also small. Therefore further research with a larger sample size would be warranted to detect whether there is indeed an association between the measures; or as shown in the present study, whether there is no significant relationship between the measures.

Given the finding in hypothesis 2 that there is a significant association between the SFI and the therapist rating of severity, perhaps the SFI is a more useful measure for the type of therapy which was received. However this would be difficult to assess as most of the therapists involved in the study use a range of therapeutic skills rather than one particular therapeutic orientation.

4.3 POSSIBLE EXPLANATIONS FOR THE RESEARCH FINDINGS

4.3.1 Lack of Statistical Power

As mentioned in hypothesis 3 there is the possibility of making a type 2 error for hypotheses 1 and 3. Initial power calculations suggested a minimum number of 21 subjects in each group and this was not achieved. Most research on therapeutic alliance has involved a small number of subjects, ranging from 8 to 144. The effect size has been estimated to be around .32, although the literature suggests a wide range of effect sizes, from .05 to .62. (Horvath and Symonds, 1991). Given the effect size detected in the second part of the study (.01), a total of 966 subjects would be required to detect any significant differences. Unfortunately due to lack of time and the low response rate, sufficient numbers of participants could not be obtained.

4.3.2 Low Response Rate

It is a constant difficulty within research to achieve a significant number of participants, particularly when there are constraints on time. This study was set up at the earliest possible date and the total amount of time given to data collection was just under a year. However the response rate was low. The literature reports a wide variance in response rates and some authors have described numerous methods of increasing response such as monetary incentives, stamped envelopes, short questionnaires and reminders (e.g. Kellerman and Herold, 2001). However whenever there is a choice to 'opt-in' to research many will choose not to, either because they are unsure of the research or perhaps with a clinical population are pre-

occupied with the therapy they are about to receive. The response rate within the present study for the first part was initially 30.68%, although this reduced to 29.71% following the cancellation of treatment from 4 patients. Of those who consented to the first part, 35.77% completed the second part.

As described above, researchers are constantly looking for methods to improve response rates. Within the present study it was hoped that by including a postage-paid and addressed envelope more people would return the questionnaires. It was also hoped that by providing people with the alternative method of bringing the questionnaire to their first appointment, compliance would also be increased. Further, questionnaires were sent out on average, 2 weeks before their initial appointment so that there was sufficient time to complete the questionnaire prior to attending. It is possible some found the questionnaires too long or too demanding in terms of time and thought. The questionnaires had been chosen with ease of completion in mind, but perhaps this was misjudged.

The difficulty with the research design was that it was important patients completed the questionnaires prior to attending therapy. This was so patients could have time to either consider their situation carefully before completing the questionnaire, or to ask questions about the study if they were unclear. Asking patients to complete the questionnaires at the first session would not only detract from the research design, it would also cause difficulties of consent and therapeutic time. Such a procedure would allow insufficient time for the patient to give consent as the Ethics Committee stipulates that patients must be given a minimum of 24 hours to consent to any

research. It would also significantly reduce the amount of time available in the session for the therapist to conduct their own assessment.

The available demographic information on those patients who did not consent to the study included gender, age, source of referral, waiting time and location seen. Having compared this information with the demographics on the group who did consent to the study, there is very little difference apparent. The proportion of males to females is roughly equivalent; the average age is similar; referrals are predominantly from GPs; average waiting time differs by 4 weeks but the range is similar; and the majority are seen at the GP surgery. Therefore it could be argued that the results obtained in the study are not reflective of a response bias. That is, the characteristics of the population who consented do not seem to be different from those who did not consent.

It was originally hoped that questionnaires could be sent to new patients as part of the routine within the department. Many departments across the country send out questionnaires prior to treatment either to gain more information before the initial assessment or to facilitate an appropriate referral route. Had the questionnaires within this study formed part of the department's procedure, it is possible ethical approval would not have been required. However it would seem that the Ethics Committee is quite inclusive of what requires ethical approval and is reluctant to allow research, even if it were audit in design, to proceed without prior approval.

4.4 METHODOLOGICAL PROBLEMS

4.4.1 Research Design

Perhaps the most significant confounding variable within the research was the therapists' behaviour. Three treatment sessions (totalling on average 3 hours) had taken place between the time patients had completed their pre-treatment questionnaires and the therapeutic alliance measure. The average time between the first appointment and the third was 4 weeks. Therefore any initial differences which may have occurred prior to the third session could have been significantly influenced by both the therapist's behaviour and by time.

Unfortunately this was beyond the control of the study. In order to control for therapist behaviour a very different design would be required. Therapists would have been selected for different therapeutic orientations and patients would have to be matched to different therapists. However given the limited number of therapists in the department and the fact that therapists are assigned to GP practices rather than patients being assigned to therapists, this would not have been acceptable to the department, or to the GPs. It is also likely that the Ethics' Committee would not have approved the study.

Also, the study involved patients who were already on the department's waiting list. Approval for a different design would have required retrospective approval from the referrers. This would have been politically inept in view of the fact that their patients had already waited some time to be seen. Given the already relatively small sample,

it would also have been likely that attempting to recruit participants in such a method would have resulted in an even smaller sample.

In addition, such a design would have been too complex given the time-constraints and lack of funding. It would also be more reflective of a randomised controlled study, which as argued in the Introduction is not reflective of day-to-day clinical practice. The author felt that an effectiveness study could produce more rich and qualitative data on therapy as it is actually practised. Therefore the design of the study allowed only the detection of the effect of filling in a particular type of questionnaire, prior to treatment.

4.4.2 Measures

As stated above, one of the main aims of the study was to look at the effects of filling in a particular type of questionnaire. The selection of questionnaires was influenced by a number of factors which will be discussed.

Solution-Focussed Intake Form

There are very few questionnaires available which are solution-focussed, so selection of a suitable questionnaire was restricted. The SFI is currently unpublished and is not bound by copyright. Therefore it can be reproduced without cost. However it has not been standardised in the UK and there is no known normative data available. As described in the Method, the SFI was revised within the clinical psychology department to account for cultural differences. However this revision has not been tested for either its reliability or validity. Therefore the results pertinent to the SFI,

from this study, must be reported cautiously as an extensive revision was made to the original SFI. In addition, as there is no available information on the reliability or validity of the original version, it is impossible to compare the revised version to the original.

The other difficulty with the SFI was that there was no information on how to score the questionnaire. It was decided by the author to follow the procedure used for the SCL-90-R so that there was some equivalence between the 2 pre-treatment measures. However the SCL-90-R has been standardised and the raw scores are converted into more meaningful scores which can be compared with the normative data. The SFI, currently, does not allow this.

The SFI also provides some useful qualitative information, however this was not used within the study. It would perhaps be useful to look at this data in more detail, for example whether patients can accurately judge how many sessions they will require, and whether some form of scoring system could be devised.

Session Rating Form

There are numerous measures available on the therapeutic alliance, which have been validated and standardised. However this work has not been carried out extensively with the SRS. It is therefore difficult to say how well the SRS correlates with other measures. The SRS is bound by copyright but requires only a licence. The SRS is a relatively new measure of the therapeutic alliance and is designed so that it can be

used frequently and within therapy. In the present study it was measured only once and the patient's response was not integrated into therapy.

A possible explanation for the non-significant results obtained in the study, could be the narrow range of scores obtained on the SRS. From a total score of 40 there was a range of only 13. That is, the lowest score was 27. The most frequent scores were 39 and 40. This is inline with Johnson's recommendations for the total score. Johnson (2000) stated that the total alliance score should be around 27 or greater, and that a score of less than 27 is indicative of some problems within the session. A score of around 27, in this study, reflected the patient scoring 'neutral' on most items rather than agreeing with either the positive or negative end of the question, rather than reporting specific problems with the session. This was the most common explanation for a lower score in the study.

With regard to the subscales, the range was particularly small on the common factors subscale (11 – 16) and the average score being 15 out of a maximum 16. Similarly the other subscales also had a small range, particularly because the total score possible for each was 8. Interestingly the *F* values for the subscales are very similar, except for the common factors (see table 9 in the Results, Chapter 3). Perhaps because any variance between the scores was so small, a much larger sample size is needed to detect any significant differences between the groups, and as stated earlier, the effect size obtained was small.

The high scores obtained on the SRS are perhaps indicative of the skills of the therapists involved in the study. As has been mentioned the single most likely confounding variable within the study was the therapists' behaviour. This would seem apparent given the high ratings of therapeutic alliance. In short, perhaps the therapists were just too good? It is possible that despite anonymity being assured with the questionnaire patients felt unable to negatively rate their therapist. It is also something which is not routinely asked of patients. More often, patients are asked to rate symptoms, or keep thought diaries, rather than how they feel about particular aspects of their treatment and therapist. Perhaps those people who are dissatisfied with such aspects are more likely to dropout of therapy. Johnson (2000) would argue that the SRS is not reflective of a satisfaction questionnaire but is an interactive tool which is used between the patient and the therapist and can facilitate a more positive relationship within therapy. Therefore patients would be actively encouraged to detail any difficulties they had experienced and improvements which could be made.

Global Assessment of Functioning

The measure of severity employed in the study was the Global Assessment of Functioning (GAF) which provides an overall, global rating of function. It has been employed within the Tayside Psychology department for approximately 5 years, with all patients assessed at first and last appointment. The advantages of the GAF are that it can be used across specialities and it is relatively quick. However the inter-rater reliability of the measure has been disputed. In a study by Howes, Haworth, Reynolds and Kavanaugh (1997) inter-rater reliability was reported to be between .40 and .56, which the authors reported to be consistent with previous research (e.g.

Goldman, Skodol and Lave, 1992). However in a paper by Friis et al, (n.d.) inter-rater reliability of the GAF was reported to be .82 within the research sites and .88 between sites.

Without conducting an analysis on the inter-rater reliability of the therapists within the present study, it is difficult to judge how reliable the GAF ratings obtained are. Therefore it is possible the findings related to the GAF are unreliable if the inter-rater reliability of the measure within the department was shown to be low. However it would be expected that there is internal consistency amongst the therapists and that as each therapist is responsible for assessing their own patients at first and last appointments, this should not distort the reliability of the GAF scores.

4.5 FUTURE RESEARCH AND IMPLICATIONS

Following on from the present study, there is scope for a number of other related research proposals which address the difficulties experienced and expand on the findings obtained.

4.5.1 Pre-Treatment Measures

The present study raises the issue of how useful pre-treatment questionnaires are to therapy and the process of therapy. Given the opposing demands on clinical psychology departments and the NHS to minimise cost but show effectiveness, the use of questionnaires requires careful consideration. The majority of questionnaires are costly and given the low response rate in the present study, there can be a

substantial amount of wastage from uncompleted forms. However if some questionnaires can be shown to enhance the process of therapy then their use can be justified.

Within this study, the degree to which questionnaires match the type of therapy received may explain the significant result obtained; that there was a significant relationship between the GAF score and the SFI. However there is also data to suggest that there is a higher number of patients dropping out of interpretative psychotherapy (e.g. Piper et al, 1999). The usefulness of SFI with therapists using SFT might facilitate therapy, enhance the therapeutic relationship and may also mean less time in treatment. It would be interesting to examine whether a similar result would be obtained using an appropriate measure prior to commencing cognitive-behavioural therapy, or for example, using a relationship focussed questionnaire prior to inter-personal therapy.

Therefore, future research could compare the use of the SFI with therapists using SFT exclusively. Research could also compare the effects of other questionnaires which are matched to particular types of therapy. Outcome data could include investigating attendance and dropout rates, length of time in treatment, and therapeutic alliance. It would be expected that patients would improve regardless of questionnaire and particular therapy, but it would be interesting to examine whether there are other differences. It may be some people are more suited to particular types of therapy. Some may favour an analytic style, whilst others might find it too intimidating. Some people may favour a more practical approach to their difficulties.

However could these differences be accounted for by symptoms or problems experienced or by other patient characteristics, or is it the case that the two are interwoven?

Within the present study the pre-treatment questionnaires were not actively used in therapy and the therapist was unaware of what questionnaire their patient had completed, or indeed whether they had completed the questionnaire. Some patients commented upon this, and on a few occasions patients asked their therapist why they were asking a particular question when they had completed a questionnaire which had asked similar questions. Future research could examine whether this had an effect on therapeutic alliance and compare a group whose questionnaires are actively used in therapy to a group who completes a questionnaire in isolation.

4.5.2 Effectiveness Studies

As the work of Seligman and others shows, there is a distinct lack of effectiveness studies published. He would encourage an increasing use of effectiveness studies over efficacy studies as they can be more reflective of what actually happens in therapy. In addition effectiveness studies can perhaps inform on what makes therapy work. The design of this study was intended to reflect more of the components of what actually occurs in therapy rather than trying to manipulate or control such variables.

The growth of randomised controlled trials and increasing use of meta-analyses has the potential to heavily influence professional practice, and this is already being shown with the development of SIGN guidelines. Such guidelines often fail to highlight the importance of the non-specific factors within therapy as the evidence-base on which they are built actively tries to exclude such factors from the research.

Without sounding overly dramatic, there is a possibility of therapy being 'hi-jacked' by such guidelines which are based on a number of flawed assumptions (Seligman, 1995). If the NHS moves towards private finance will therapists be curtailed by insurance companies, as is the case in the USA, with treatment being based on the 'evidence' of randomised controlled trials rather than actual clinical practice? We can already see the influence of insurance companies on treatment options for those sustaining psychological traumas following injury e.g. EMDR as 'treatment of choice' for PTSD. The importance of effectiveness studies can not be underestimated, and a strong evidence-base is required to justify clinical practice.

4.5.3 Therapeutic Alliance

There is a growing recognition of the importance of such factors as the therapeutic alliance. The Department of Health recently published guidelines on 'Treatment Choice in Psychological Therapies and Counselling' (DoH, February, 2001). The guidelines highlight the importance of the therapeutic alliance, recognising its contribution to outcome in all forms of psychological therapies. It makes specific recommendations about considering both the therapeutic relationship and the impact

of the therapeutic alliance. Such documents can only help to increase the awareness of other factors in therapy and it is the role of research to continue to demonstrate their importance.

There are numerous possibilities for future research in to the therapeutic alliance. It has been widely shown that the therapeutic alliance is positively associated with therapeutic outcome, but it would be interesting to demonstrate this with the Session Rating Form. The subscales which form the SRS could also be investigated more closely to see whether particular factors, for example hope, are more important than other factors, such as 'smoothness' of the session.

As the SRS is a relatively new measure, there are many studies which could be conducted. As the SRS is intended for use at each session, further research could look at whether there is an 'optimum' time to assess the alliance and whether frequent assessment is useful. It would also be interesting to examine the SRS within therapy, as in this study the clinician was not informed of the SRS scores. For example, is there a more positive effect on the therapeutic alliance if the SRS is used explicitly in therapy and measured at a later stage? It would be hypothesised that it should be as the idea with SRS is that it allows the client to feel more involved in therapy, shared agenda, shared goals, and if there are difficulties identified they can be discussed at the following session.

4.6 SUMMARY AND CONCLUSIONS

The main hypotheses being tested in the study were that administering a solution-focussed questionnaire prior to treatment would have a positive effect on attendance at the first 3 sessions of therapy and would also have a positive effect on a measure of the therapeutic alliance. The experimental group was compared to a group receiving a symptom-focussed questionnaire and a control group, receiving no questionnaire. However, results from this study suggested there was no evidence that using a solution-focussed questionnaire prior to treatment had an effect on either attendance at therapy or therapeutic alliance. However the main difficulty with the current research was that it lacked statistical power and perhaps a replication of the study with more subjects would detect some significant findings.

The study also examined the relationship between the different patient and therapist rated measures. As predicted, there was a significant relationship between the SFI and the GAF, but not between the SCL-90-R and GAF. It was thought that a possible explanation for this finding was that patients who had completed the SFI had altered their perceptions about their problems and their presentation at therapy had been altered. The results also showed that there were no significant relationships between the pre-treatment questionnaires and the therapeutic alliance measure, which is consistent with past research.

This research would suggest the need for further exploration in to both the use of pre-treatment measures and therapeutic alliance measures, within therapy. Given the growing demands within the NHS for evidence-based practice and departments being

led by clinical governance, there is a very real need for clinicians to publish research which demonstrates the effective components of therapy. The non-specifics within therapy need to be highlighted and recognised. Therapy is not often about offering a patient 8 – 10 sessions and a follow-up at 3 months. It is rarely about applying one technique to one problem that neatly fits a DSM-IV check box. Patients present at therapy with a wide range of problems, sometimes they can be helped within a short space of time, but often a longer time period is required. Most therapists work idiosyncratically, they have to be guided by what the patient brings to therapy and help facilitate the necessary change.

It is encouraging to read Department of Health guidelines which recognise the importance of the therapeutic alliance and hopefully such realisation can be incorporated within future research. The difficulties measuring the non-specific factors in therapy can be overcome, with measures such as the SRS, and the value of including such variables in research rather than excluding them should be upheld. This can help us to understand more fully what works in psychotherapy and how best such factors can be enhanced within the therapeutic relationship which in turn will allow a more successful process through therapy for the patient.

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APPENDIX 1

Solution-Focussed Intake Form

(Version 1)

Client Information Form

Welcome to (Agency name/program). We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as potential solutions in helping you get your life back on track. Please note - the information is confidential and will not be released to anyone without your written permission.

Sources of Stress

Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you stress.

1. _____
2. _____
3. _____
4. _____

Adult Strength Scale

Please circle the areas below that apply to you

Home

1. I feel part of the family	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my spouse	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am physically healthy	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I have an enjoyable social life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I feel accepted by others	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am a good father/mother	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I participate in decision making	Seldom	Just a little	Pretty Much	Very Much	N/A

Work

1. I get to work on time	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am respected by my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am respected by my supervisor(s)	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I enjoy working	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I have realistic career goals	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I am a hard worker	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I balance home and work	Seldom	Just a little	Pretty Much	Very Much	N/A

Emotional

1. I cope well with frustration	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I cope well with disappointment	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I use anger constructively	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am satisfied with life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I accept responsibilities for my mistakes	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I drink (alcohol) responsibly	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I can take constructive criticism	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I think before I act	Seldom	Just a little	Pretty Much	Very Much	N/A
9. I have good self-esteem	Seldom	Just a little	Pretty Much	Very Much	N/A

Social

1. I make and keep friends	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I'm open to new ideas	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am considerate of others	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I stand up for myself	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I show leadership	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I'm comfortable around others	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I get along with others	Seldom	Just a little	Pretty Much	Very Much	N/A

Attention

1. I cope with external distraction	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I maintain attention to tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I follow through on tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A

Problems That You Are Struggling With

Please check ( ) those that apply to you.

( ) Depression
( ) Anxiety or panic attacks
( ) Suicidal thoughts
( ) Suicidal actions
( ) Brother/sister problem
( ) Violence in family-actual or threatened
( ) Sexual problem
( ) Unemployed
( ) Legal problems
( ) Compulsive gambling
( ) Death of a loved one
( ) Parent-child conflict (self)
( ) Parent-child conflict (spouse)
( ) Marital/relationship problems
( ) Remarried family problems
( ) Anger/temper problems
( ) Job/school problem
( ) Sexual Abuse - Adult/Child
( ) Low self - esteem
( ) Eating problems
( ) Major losses/difficult changes
( ) Communication problems
( ) Alcohol/Drugs: Please include history, current use, as well as type, amount, and frequency

Additional Space (interviewer comments if needed):

Problems With Coping

Please check ( ) those that apply to you

( ) Sleep problems
( ) Difficulty falling asleep
( ) Waking in the middle of the night
( ) Waking too early
( ) Sleeping to much
( ) Nightmares
( ) Moody or crying more than usual
( ) Difficulties concentrating
( ) Problems remembering things
( ) Withdrawing from others
( ) Repeated actions I can't stop
( ) Can't stop washing hands/body, counting or checking things
( ) People picking on me
( ) Self-harm
( ) I cut myself
( ) I burn myself
( ) I hit myself

( ) Change in appetite
( ) Gaining weight (specify _____)
( ) Losing weight (specify _____)
( ) Not hungry or not eating
( ) Throwing up after eating
( ) Feeling sick to my stomach
( ) Constipation or diarrhea
( ) Feeling guilty, worthless, or hopeless
( ) Fatigue/low energy
( ) Hyper/too much energy
( ) Loss of interest in things
( ) Disturbing thoughts I can't stop
( ) Low self esteem
( ) Hallucinations
( ) I hear things that are not real
( ) I see things that are not real
( ) I smell things that are not real
( ) I feel things that are not real

List Any Previous Suicide Attempts (if none, write "None")

When Method

List Previous Inpatient Psychiatric and/or Drug-alcohol Rehab. Hospitalizations (if none, write "None")

Dates (from-to) Reason

Previous or Current Counseling (if none, write "None")

Therapist or Agency From/to Focus of Sessions

What was helpful and/or not helpful about your previous/current counseling experience?_____

Current medication you regularly take - please include prescription, over the counter, and any herbal remedies (if none, write "None")

Name of Medication Dosage How often/day

_____

_____

_____

Are You Allergic to Any Drugs (Please List)?

_____

Are you currently on probation? Have you ever been in jail or prison? (if yes, please explain)

_____

Family Information

Please list the people that you currently live with

Name	Relationship	Age

Do you have other children not living with you? If yes, please give names and ages_____

_____

Does your family have any psychiatric or substance abuse history? (please list)_____

_____

Does your family have a history of major health problems? (please list)

_____

What is your relationship like with your parents?

_____

Please list family, friends, support groups and community groups that are helpful to you

_____

_____

_____

Have you ever been in the military? If yes, please provide details below

_____

_____

What is your highest level of your schooling? _____

Are there any guns or weapons in your house (please list below?)

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation.

0%-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Choices Available To You

Your input in your clinical treatment is very important to us. Please check below the type of clinical service(s) that you believe will be most useful to you:

( ) Individual therapy
( ) Male therapist preferred
( ) Female therapist preferred
( ) Makes no difference
( ) Group therapy
( ) Family Counseling
( ) Couples Counseling
( ) Consultation with Psychiatrist
( ) Consider for medication
( ) Monitor medication

Your Goals in Counseling

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1._____

2._____

3._____

How Many Sessions Do You Think You Will Need To Get Back On Track?

Please place a checkmark ( ) in the answer which best describes your expectations.

( ) 1-3 sessions ( ) 4-6 sessions ( ) 7-9 sessions ( ) 10-12 sessions ( ) 13-15 sessions
( ) Other (please specify): _____

What Do You Think Of This Form?

( ) Shouldn't be used ( ) It was okay ( ) Questions too personal
( ) Didn't really understand the questions ( ) It was a good way to gather needed information

Suggestions to improve this form:

_____
_____
_____

Signature: _____ Date: _____

APPENDIX 2

Solution-Focussed Intake Form

(Version 2)

Name: _____

Date: _____

Personal Strengths

Please circle the areas below that apply to you

Home

1. I feel part of the family	Rarely	Sometimes	Often	Most of the time	N/A
2. I get along with my spouse	Rarely	Sometimes	Often	Most of the time	N/A
3. I am physically healthy	Rarely	Sometimes	Often	Most of the time	N/A
4. I have an enjoyable social life	Rarely	Sometimes	Often	Most of the time	N/A
5. I feel accepted by others	Rarely	Sometimes	Often	Most of the time	N/A
6. I am a good father/mother	Rarely	Sometimes	Often	Most of the time	N/A
7. I participate in decision making	Rarely	Sometimes	Often	Most of the time	N/A

Work

1. I get to work on time	Rarely	Sometimes	Often	Most of the time	N/A
2. I get along with my co-workers	Rarely	Sometimes	Often	Most of the time	N/A
3. I am respected by my co-workers	Rarely	Sometimes	Often	Most of the time	N/A
4. I am respected by my supervisor(s)	Rarely	Sometimes	Often	Most of the time	N/A
5. I enjoy working	Rarely	Sometimes	Often	Most of the time	N/A
6. I have realistic career goals	Rarely	Sometimes	Often	Most of the time	N/A
7. I am a hard worker	Rarely	Sometimes	Often	Most of the time	N/A
8. I balance home and work	Rarely	Sometimes	Often	Most of the time	N/A

Emotional

1. I cope well with frustration	Rarely	Sometimes	Often	Most of the time	N/A
2. I cope well with disappointment	Rarely	Sometimes	Often	Most of the time	N/A
3. I use anger constructively	Rarely	Sometimes	Often	Most of the time	N/A
4. I am satisfied with life	Rarely	Sometimes	Often	Most of the time	N/A
5. I take responsibility for my mistakes	Rarely	Sometimes	Often	Most of the time	N/A
6. I drink (alcohol) responsibly	Rarely	Sometimes	Often	Most of the time	N/A
7. I can take constructive criticism	Rarely	Sometimes	Often	Most of the time	N/A
8. I think before I act	Rarely	Sometimes	Often	Most of the time	N/A
9. I have good self-esteem	Rarely	Sometimes	Often	Most of the time	N/A

Social

1. I make and keep friends	Rarely	Sometimes	Often	Most of the time	N/A
2. I'm open to new ideas	Rarely	Sometimes	Often	Most of the time	N/A
3. I am considerate of others	Rarely	Sometimes	Often	Most of the time	N/A
4. I stand up for myself	Rarely	Sometimes	Often	Most of the time	N/A
5. I show leadership	Rarely	Sometimes	Often	Most of the time	N/A
6. I am able to compromise	Rarely	Sometimes	Often	Most of the time	N/A
7. I'm comfortable around others	Rarely	Sometimes	Often	Most of the time	N/A
8. I get along with others	Rarely	Sometimes	Often	Most of the time	N/A

Attention

1. I cope with external distraction	Rarely	Sometimes	Often	Most of the time	N/A
2. I maintain attention to tasks	Rarely	Sometimes	Often	Most of the time	N/A
3. I follow through on tasks	Rarely	Sometimes	Often	Most of the time	N/A
4. I am able to compromise	Rarely	Sometimes	Often	Most of the time	N/A

Other Supports
Please list any supports which are helpful to you, eg: family, friends, support groups and communitygroups, etc.

Sources of Stress
Please list the reasons that bring you to a Clinical Psychologist. This may include certain problems, issues, significant losses or changes that are causing you stress.

Other Important Information
Please list anything else (experiences, circumstances, etc) which you think would be useful for your therapist to know about you.

Current Functioning
Please place an "X" on the following scale to indicate how well you are coping at the present time.

Not coping at all |——————————————————————| Coping the best I can, considering my situation

Your Goals In Therapy
Goals are very important in therapy. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in therapy. Please be as specific as possible.

How Many Sessions Do You Think You Will Need?
Please tick the answer which best describes your expectations.

☐ 1-3 sessions ☐ 4-6 sessions ☐ 7-9 sessions
☐ 10-12 sessions ☐ 13-15 sessions ☐ Other (please specify): _____

APPENDIX 3

Session Rating Form

(Version 1)

SESSION RATING

Name_____ Date_____ Therapist

Therapy is a cooperative relationship. Please rate today's session. Be honest and frank, to be the most helpful to your counselor. Read each set of descriptions. Circle the number that best describes your reaction, from 0 to 4. Use the rating system below:

AGREE WITH THIS SIDE **NEUTRAL** **AGREE WITH THIS SIDE.**

4 3 2 1 0

(Under each set of statements, circle the number that best describes your feelings about today's session)

1. ACCEPTANCE

I felt accepted. I felt criticized or judged.

4 3 2 1 0

2. LIKING, POSITIVE REGARD

My therapist liked me. The therapist pretended to like me or seemed to not like me.

4 3 2 1 0

3. UNDERSTANDING

My counselor understood me and my feelings. My counselor didn't understand me or my feelings.

4 3 2 1 0

4. HONESTY AND SINCERITY

My therapist was honest and sincere. My therapist was not sincere, was pretending.

4 3 2 1 0

5. AGREEMENT ON GOALS

We worked on my goals; my goals were important. We worked on my counselor's goals; My goals didn't seem important.

4 3 2 1 0

6. AGREEMENT ON TASKS

I approved of the things we did in the session or what I was asked to do as a homework assignment I didn't like what we did in today=s session or what I was asked to do as a homework assignment

4 3 2 1 0

7. SMOOTHNESS OF THE SESSION

The session was smooth; I felt comfortable. The session was rough; I felt uncomfortable.

4 3 2 1 0

8. DEPTH OF THE SESSION

The session was deep. We got to the heart of things. The session was shallow. We stayed on the surface.

4 3 2 1 0

9. HELPFULNESS, USEFULNESS

I found the session helpful The session was not helpful

4 3 2 1 0

10. HOPE

I felt hopeful after the session I felt hopeless after the session.

4 3 2 1 0

One more thing: What could help the next session go better? Please continue on the back if necessary.

APPENDIX 4

Session Rating Form

(Version 2)

SESSION RATING - V. 2.0

Name_____ Date_____ Session No. _____Therapist _____

Therapy is a cooperative relationship. Please rate today's session. Be honest and frank, to be the most helpful to your counselor. P
set of descriptions. Circle the number that best describes your reaction, from 0 to 4. Use the rating system below:

AGREE WITH THIS SIDE		NEUTRAL		AGREE WITH THIS SIDE.
4	3	2	1	0

(Under each set of statements, circle the number that best describes your feelings about today's session)

1. ACCEPTANCE

I felt accepted.				I felt criticized or judged.
4	3	2	1	0

2. LIKING, POSITIVE REGARD

My therapist liked me.				The therapist pretended to like me or seemed to not like me.
4	3	2	1	0

3. UNDERSTANDING

My counselor understood me and my feelings.				My counselor didn't understand me or my feelings.
4	3	2	1	0

4. HONESTY AND SINCERITY

My therapist was honest and sincere.				My therapist was not sincere, was pretending.
4	3	2	1	0

5. AGREEMENT ON GOALS

We worked on my goals; my goals were important.				We worked on my counselor's goals; My goals didn't seem important.
4	3	2	1	0

6. AGREEMENT ON TASKS

I approved of the things we did in the session or what I was asked to do as a homework assignment				I didn't like what we did in today=s session or what I was asked to do as a homework assignment
4	3	2	1	0

7. AGREEMENT ON TREATMENT

The treatment I received was right for me				There was something wrong with the treatment I received
4	3	2	1	0

8.PACE OF THE SESSION

The session moved along at the right pace				The session moved too fast or too slowly
4	3	2	1	0

9. HELPFULNESS, USEFULNESS

I found the session helpful				The session was not helpful
4	3	2	1	0

10. HOPE

I felt hopeful after the session				I felt hopeless after the session.
4	3	2	1	0

One more thing: What could help the next session go better? Please continue on the back if necessary.

APPENDIX 5

Global Assessment of Functioning

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (**Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 | 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 | 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 | 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

APPENDIX 6

Patient Information Sheet (A)

TAYSIDE AREA CLINICAL PSYCHOLOGY DEPARTMENT

Your ref:

Our ref:

Enquiries to: Ext 2383

Murray Royal Hospital
PERTH PH2 7BH
Telephone 01738 621151
Fax: 01738 440431

PATIENT INFORMATION SHEET (A)

A Comparison of Effect of Pre-Treatment Questionnaires on Therapeutic Alliance and Attendance Rates

I would be grateful if you would consider participating in this study. Please read the information below. If you have any further questions about the research please contact me at the above telephone number.

All patients seen over a 6 month period are being asked to participate in this study.

Background to the Study: At present there is little information about what other factors influence therapy. I am interested in what factors influence pre-treatment change and how this might improve the delivery of care.

What does the Study Entail? You will receive treatment as usual. There will be no alteration to the standard treatment you would normally receive either in the number of appointments, length of treatment and type of treatment. The only additional requirement is that, if you decided to take part, you complete the enclosed questionnaire and return it along with the consent form, in the stamped addressed envelope. Further, if you decide to take part in the study you will be asked to complete a questionnaire after the 3rd session.

The proposed research may be of benefit to future patients as we hope to determine what is most useful to patients and their therapy.

What will happen to the information collected in this Study? Data from the questionnaires will be coded and analysed in accordance with the Data Protection Act. No other individual will have access to the data. Your GP has been informed of the research. Your GP will be informed of your treatment progress in the standard manner, usually by letter from your Clinical Psychologist. If you so wish, I will be happy to provide you with a copy of the overall study results.

What are my rights? If at any time you require more information regarding the study please do contact me at the above address, or telephone number. It must be emphasised that participation in this study is entirely voluntary and that you are free to refuse to take part or to withdraw at any time without having to give a reason and without this affecting the treatment which is being offered to you.

Please note:
The Tayside Committee on Medical Research Ethics that has responsibility for scrutinising all proposals for medical research on humans in Tayside has examined the proposal and has raised no objections from the point of view of medical ethics.

Monitors of the Tayside Committee on Medical Research Ethics may examine records associated with the study and all information will be regarded as strictly confidential.

PARTICIPATION IN THIS STUDY IS ENTIRELY VOLUNTARY AND YOU ARE FREE TO REFUSE TO TAKE PART OR TO WITHDRAW FROM THE STUDY AT ANY TIME WITHOUT HAVING TO GIVE A REASON AND WITHOUT THIS AFFECTING YOUR FUTURE MEDICAL CARE OR YOUR RELATIONSHIP WITH MEDICAL STAFF LOOKING AFTER YOU.

Dr Maurice Winton
Clinical Psychology Department
Murray Royal Hospital
01738 562383
July 2000

APPENDIX 7

Patient Information Sheet (B)

TAYSIDE AREA CLINICAL PSYCHOLOGY DEPARTMENT

Your ref:

Our ref:

Enquiries to: Ext 2383

Murray Royal Hospital
PERTH PH2 7BH
Telephone 01738 621151
Fax: 01738 440431

PATIENT INFORMATION SHEET (B)

A Comparison of Effect of Pre-Treatment Questionnaires on Therapeutic Alliance and Attendance Rates

I would be grateful if you would consider participating in this study. Please read the information below. If you have any further questions about the research please contact me at the above telephone number.

All patients seen over a 6 month period are being asked to participate in this study.

Background to the Study: At present there is little information about what other factors influence therapy. I am interested in what factors influence pre-treatment change and how this might improve the delivery of care.

What does the Study Entail? You will receive treatment as usual. There will be no alteration to the standard treatment you would normally receive either in the number of appointments, length of treatment and type of treatment. The only additional requirement is that, if you decided to take part, you will be asked to complete a questionnaire after the 3rd session. If you decide to take part please complete and return the consent form in the pre-paid envelope.

The proposed research may be of benefit to future patients as we hope to determine what is most useful to patients and their therapy.

What will happen to the information collected in this Study? All information collected during the course of the study will be collected by myself. Data from the questionnaires will be coded and analysed in accordance with the Data Protection Act. No other individual will have access to the data. Your GP has been informed of the research. Your GP will be informed of your treatment progress in the standard manner, usually by letter from your Clinical Psychologist. If you so wish, I will be happy to provide you with a copy of the overall study results.

What are my rights? If at any time you require more information regarding the study please do contact me at the above address, or telephone number. It must be emphasised that participation in this study is entirely voluntary and that you are free to refuse to take part or to withdraw at any time without having to give a reason and without this affecting the treatment which is being offered to you.

Please note:
The Tayside Committee on Medical Research Ethics that has responsibility for scrutinising all proposals for medical research on humans in Tayside has examined the proposal and has raised no objections from the point of view of medical ethics.

Monitors of the Tayside Committee on Medical Research Ethics may examine records associated with the study and all information will be regarded as strictly confidential.

PARTICIPATION IN THIS STUDY IS ENTIRELY VOLUNTARY AND YOU ARE FREE TO REFUSE TO TAKE PART OR TO WITHDRAW FROM THE STUDY AT ANY TIME WITHOUT HAVING TO GIVE A REASON AND WITHOUT THIS AFFECTING YOUR FUTURE MEDICAL CARE OR YOUR RELATIONSHIP WITH MEDICAL STAFF LOOKING AFTER YOU.

Dr Maurice Winton
Clinical Psychology Department
Murray Royal Hospital
01738 562383
July 2000

APPENDIX 8

Consent Form

A Comparison of Effect of Pre-Treatment Questionnaires on Therapeutic Alliance and Attendance Rates

Consent Form

(The patient should complete this form himself/herself)

	PLEASE CROSS OUT AS NECESSARY
Have you read the Patient Information Sheet?	YES/NO
Have you had an opportunity to ask questions and discuss this study?	YES/NO
Have you received satisfactory answers to all of your questions?	YES/NO
Have you received enough information about the study?	YES/NO
Do you understand that participation is entirely voluntary?	YES/NO
Do you understand that you are free to withdraw from the study: * at any time? * without having to give a reason for withdrawing? * without this affecting your future medical care?	YES/NO
Do you agree to take part in this study?	YES/NO

Patient's Signature ..... Date .....

Patient's name in block letters .....

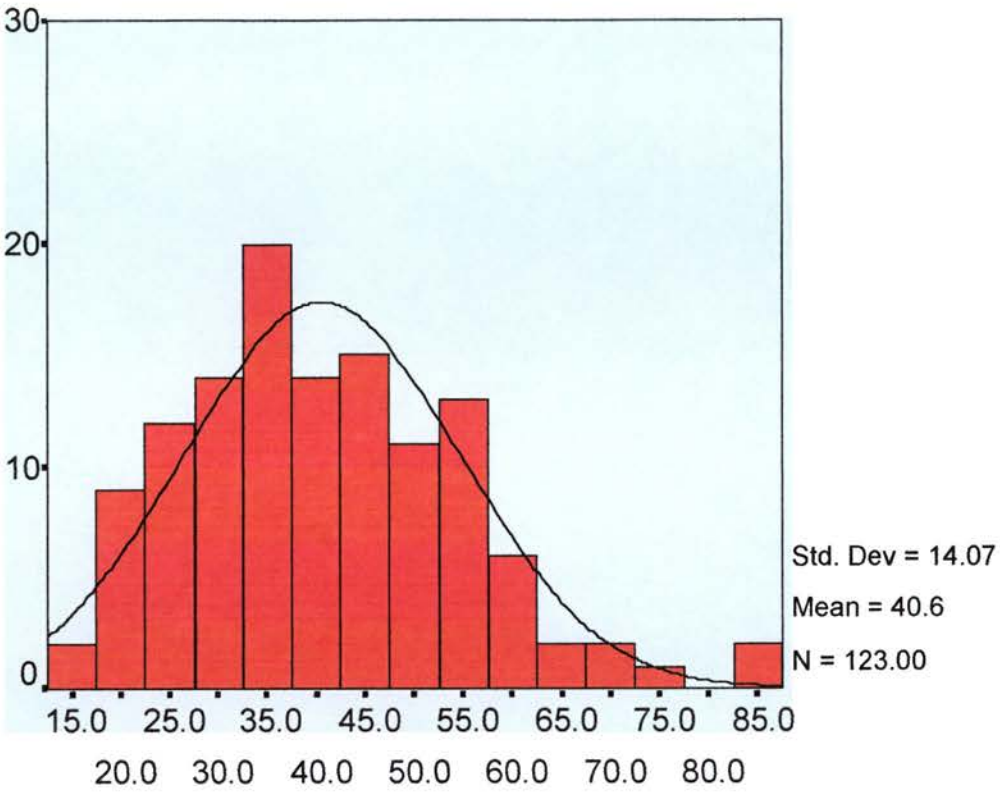
Telephone number where patient can be contacted:

..... (Home) ..... (Work)

APPENDIX 9

Histogram of Age

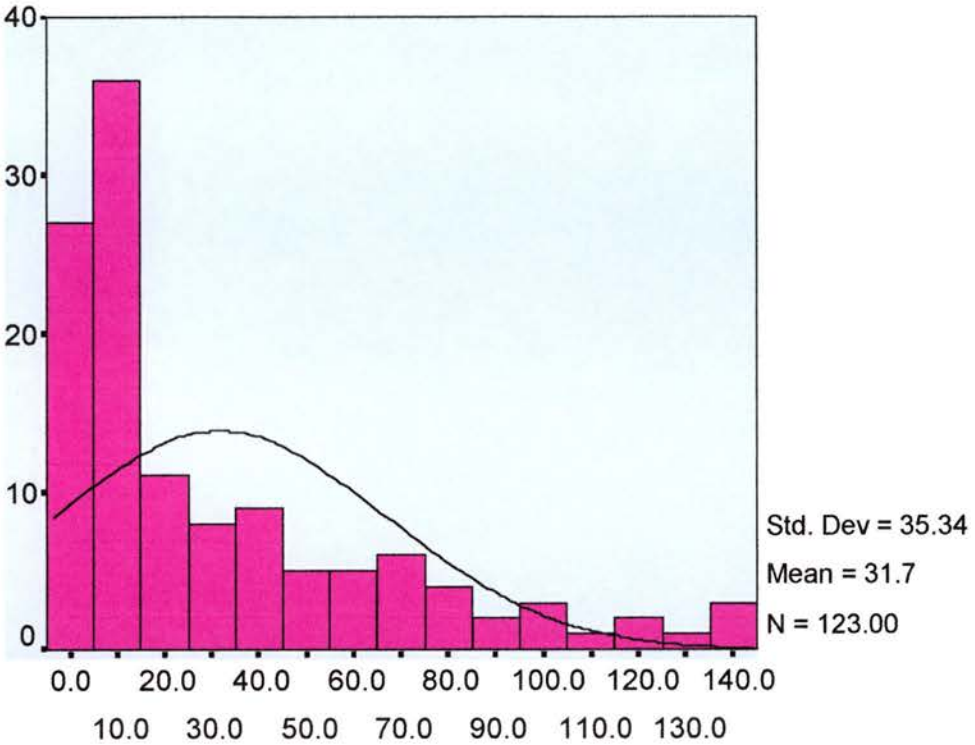
Figure 6 Histogram of Age



APPENDIX 10

Histogram of Waiting Time

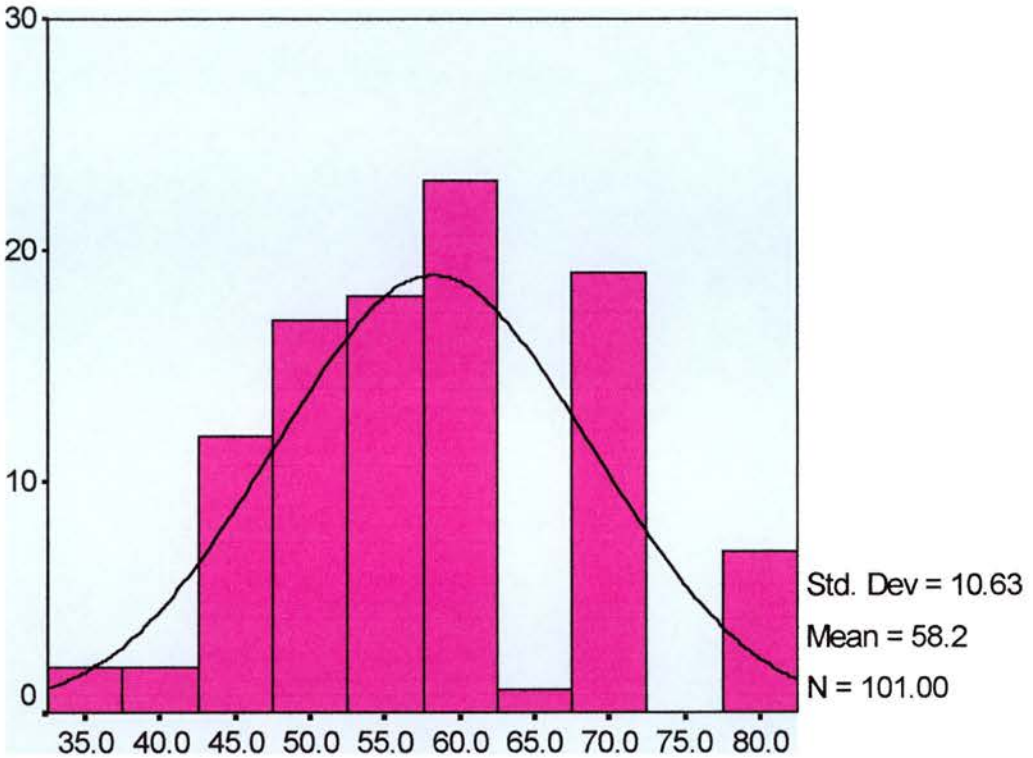
Figure 7 Histogram of Waiting Time



APPENDIX 11

Histogram of Initial GAF score

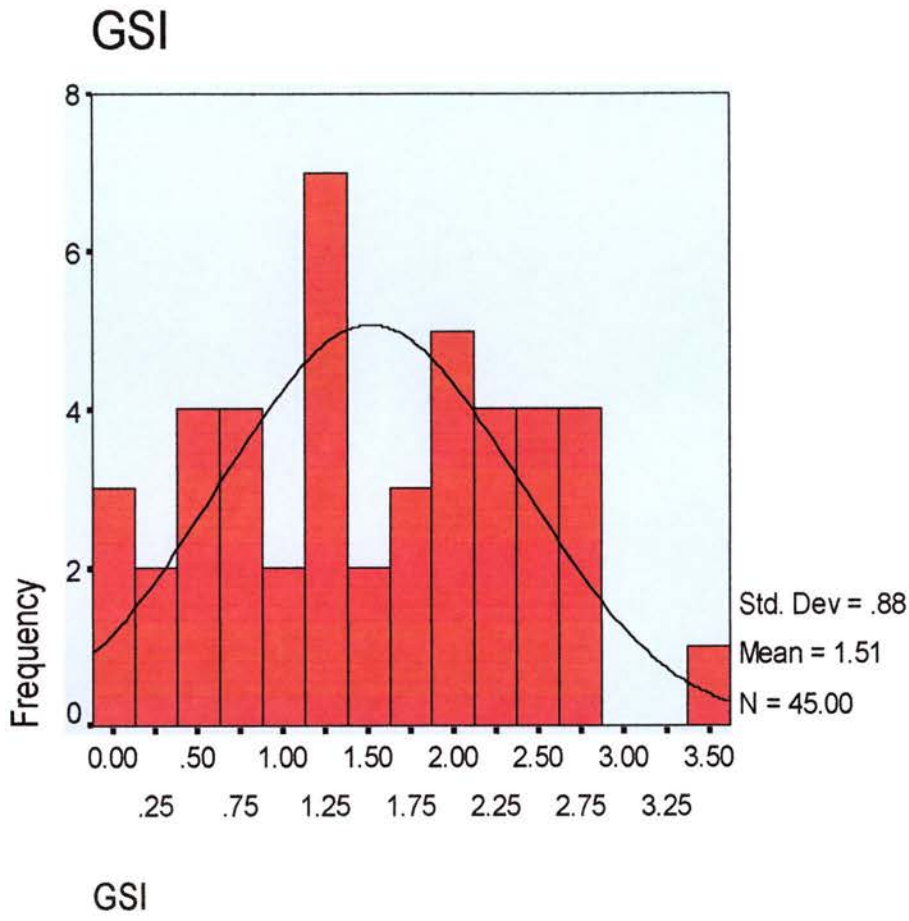
Figure 8 Histogram of Initial GAF score



APPENDIX 12

Histogram of Global SCL-90-R score

Figure 9 Histogram of Global SCL-90-R score



APPENDIX 13

Histogram of Global SFI score

Figure 10 Histogram of Global SFI score